

# ACT NOW: END AIDS

## COMMUNITY ROADMAP EXECUTIVE SUMMARY 2020

*ACT NOW: END AIDS is a national coalition of community-based organizations, health departments, and national organizations committed to ending AIDS as an epidemic in the United States. The coalition hosts learning collaboratives to share key practices; works to have Ending the Epidemic (EtE) become part of the national discourse with key decision makers; and supports health departments across the country with technical assistance in the writing and implementation of EtE plans and processes.*

**W**ith almost 40,000 new cases each year, HIV continues to be a major public health crisis in the U.S., and it is compounded by the syndemics of opioid use, viral hepatitis, sexually transmitted infections (STIs), and tuberculosis (TB). While the more than 1.2 million people living with HIV in the U.S. reside in every congressional district, state, and territory, new cases of HIV and HIV/AIDS-related deaths are increasingly concentrated in communities of color, among members of the LGBTQ community, and in the Southern states.

Even before Health and Human Services (HHS) Secretary Alex Azar announced a plan in early 2019 to end the U.S. HIV epidemic, communities across the U.S. had begun taking concrete steps to end their state and local HIV epidemics.<sup>1</sup> Leaning into this innovation, HHS's plan to end the HIV epidemic in the United States created new resources as well as an increased urgency to develop localized strategies to improve knowledge of HIV status. It also ensured sustained engagement in care and viral suppression among those living with HIV and expanded the use of preventive tools like pre- and post-exposure prophylaxis for people who are at higher risk of HIV acquisition. By focusing on the 48 counties, seven states, one district, and one U.S. territory that make up half of all HIV diagnoses, resources will shift to places that have been the most impacted by the epidemic.

*(COVID-19) threatens the progress many jurisdictions have made with their own plans and has made implementation efforts more challenging in jurisdictions that have recently been funded under the federal plan.*

But one year into the planning and launch of the federal Ending the HIV Epidemic (EHE) plan, the novel coronavirus (COVID-19) threatens the progress many jurisdictions have made with their own plans and has made implementation efforts more challenging in jurisdictions that have recently been funded under the federal plan. While it has been shown that an HIV diagnosis does not put one at more risk for contracting COVID-19,

---

<sup>1</sup> *Ending the Epidemic plans have been announced in eight states (and DC), two counties, and two cities and are being developed in an additional seven states, one county, and nine cities. More information can be found at <https://www.nastad.org/maps/ending-hiv-epidemic-jurisdictional-plans>*

the pandemic has, and may continue to have, an impact on HIV prevention and care for years to come in the following ways:

- Hospital and clinic closures have made HIV testing and labs/screening for pre-exposure prophylaxis (PrEP) far more difficult in many parts of the country.
- These closures have also made appointments for regular clinic visits or access to pharmacies more difficult.
- In many cities, an already aging infectious disease workforce had to shift their attention entirely to caring for COVID-19 patients, leaving people with HIV with fewer options for care.
- COVID-19 care is straining many state and city budgets, jeopardizing resources that fund HIV prevention and care.
- Many people lost jobs and health insurance as a result of COVID-19, putting a strain on state Ryan White Care programs.
- Many HIV researchers doing critical research on novel HIV therapies, vaccines, and cures have been pulled into COVID-19 research, possibly slowing the pipeline of HIV therapies.
- Due to the lack of a national coordinated COVID-19 response plan and the mixed messages and downright false statements coming from Trump Administration officials, public trust in health care, public health, and clinical research authorities is damaged, perhaps for many years to come, making our efforts to expand biomedical prevention options or anti-stigma campaigns such as Undetectable Equals Untransmittable (U=U) increasingly challenging.
- According to a survey done by NASTAD in August 2020, more than 90 percent of health department staff in jurisdictions within the federal EHE plan report being detailed to the COVID-19 response.
- With many programs shifting to at-home services it is difficult for HIV prevention programs to deliver effective outreach and prevention.

***According to a survey done by NASTAD in August 2020, more than 90 percent of health department staff in jurisdictions within the federal EHE plan report being detailed to the COVID-19 response.***

In addition to the impact the COVID-19 pandemic has had on health care and public health systems, the United States is also on the precipice of massive social upheaval, the likes of which have not been seen in over half a century. The late-May murder of George Floyd by officers of the Minneapolis Police Department sparked outrage across the country (and across all demographics), and many large-scale Black Lives Matter protests sprung up in cities, suburbs, and rural areas around the nation. These uprisings, protesting the police violence against not only George Floyd but Black people in the U.S. more broadly, were met with increased police violence against protesters, as well as by white nationalist groups who have mobilized counter protests and enacted violence that has caused the deaths of several pro-Black Lives Matter activists.

But these protests spread beyond the police and beyond issues of law enforcement. A massive June 14th, 2020 New York rally in response to increased numbers of Black and Brown transgender and gender nonconforming people who have been brutalized, criminalized, and killed this year prompted the movement to address its intersectionality gaps and ensure that ALL Black lives matter. Many people in public health (including HIV) began to speak out against the racism and white supremacy that leads to racial disparities in both access to quality health care and outcomes related to health. "Racism is a public health crisis" has become a rallying cry for Black and Brown public health and health care advocates and providers, including those living with and treating HIV. Calls have been made for individual institutions to address their lack of diversity in staffing (or in executive positions), as well as in health care outcomes. The rallying cry to "defund the police" comes from communities

who see far more investment in law enforcement than they do in public health, education, housing, and other services that have been shown to positively affect health outcomes, including reducing the incidence of HIV. Calls have even been made for the Centers for Disease Control and Prevention (CDC) and other public health entities to officially declare racism a public health issue and take steps to address the ways white supremacy adversely impacts the lives of Black, Latinx, Native American/Indigenous, Middle Eastern, and Asian-Pacific Islander communities. But with an administration that has actively courted favor with white nationalist groups, any efforts by public health agencies and researchers to educate impacted communities on the positive role that biomedicine can play in addressing disparities have become increasingly complicated. In short, a confusing and uncoordinated COVID-19 response (that disproportionately impacted Black, Latinx, and Native American communities) combined with the apparent impunity of law enforcement to kill Black citizens has undermined trust in the government and made ending the HIV epidemic even more challenging.

**Despite these emerging challenges, the United States now has the tools and capability to end the HIV epidemic at home. COVID-19 has presented us with an opportunity to address the longstanding problems in our healthcare system and public health infrastructure that have made ending HIV as an epidemic elusive for many years. Facing these systemic challenges to end the COVID-19 pandemic would support our efforts to end the HIV epidemic. Improving our HIV prevention, treatment, and care infrastructure may also support efforts to end COVID-19 as a pandemic. We must also urgently seek to eliminate the related syndemics of opioid use, viral hepatitis, STIs, and TB. The undersigned call on the U.S. government to further scale-up resources and enact new legislative and regulatory changes to achieve the goal of ending the HIV epidemic in the United States by 2025 as laid out by the Department of Health & Human Services (HHS) in 2019.**

Though there is no vaccine or cure, highly effective antiretroviral therapy, taken as treatment or prevention, provides a means to end our HIV epidemic by dramatically reducing new HIV cases, ending AIDS deaths, and eliminating disparities in access to quality HIV prevention and treatment. We now know that for people living with HIV, retention in HIV treatment that suppresses viral load to an undetectable level both sustains optimal individual health and eliminates the risk of sexual transmission of the virus. Successful HIV prevention for HIV-negative individuals is available through a combination of sexual health education, routine HIV screening, wide-scale access to both pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for those who need it, and syringe access and other harm reduction services. Comprehensive insurance coverage of these interventions is also an essential preventive health care service.

U.S. innovation and leadership on HIV have laid the foundation for decisive action to end the epidemic. Numerous federal government departments, agencies, and programs are involved in the domestic HIV/AIDS response; together they provide disease surveillance, prevention, care, support services, and research. The Centers for Disease Control and Prevention (CDC) leads U.S. surveillance and prevention activities, which are carried out in conjunction with state and local health departments and community-based organizations (CBOs). Federal health care programs including Medicaid, Medicare, the Ryan White HIV/AIDS Program, Community Health Centers, and the Veterans Administration provide care, treatment, and supportive services. The Housing Opportunities for Persons with AIDS (HOPWA) program, as well as other safety net services available through the Department of Housing and Urban Development (HUD), provides essential access to affordable housing for low-income people living with, affected by, or made vulnerable to HIV by an unequal distribution of resources and systemic gaps in access to health care services. The Social Security Administration's income programs for those who are disabled—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)—are important sources of support and financial stability. The passage of the Patient Protection and Affordable Care Act (ACA) in March 2010 provided new opportunities for expanding health care access, prevention, and treatment services for millions of people in the U.S., including many people living with or vulnerable to HIV, while also offering key nondiscrimination efforts.

*Calls have even been made for the Centers for Disease Control and Prevention (CDC)... to officially declare racism a public health issue.*

A variety of other departments and programs also play key roles in this work. The Departments of Justice Civil Rights Division, Education, Labor, Transportation, Defense, Agriculture, the Bureau of Prisons, and others all have crucial roles to play in ending new HIV transmissions in the U.S. and supporting the health of people living with HIV.

We can change the trajectory of the U.S. HIV epidemic by setting and meeting the ambitious but achievable goal of reaching a 95/95/95 framework for HIV care (95 percent of people living with HIV are aware of their HIV status, 95 percent of diagnosed individuals are retained in care, and 95 percent of individuals on antiretroviral therapy are virally suppressed), significantly increasing access to combination prevention for people who are HIV negative and taking concrete action to ensure that no population or region is left behind. But we must bring all available treatment and prevention tools to scale now to have the necessary impact on the epidemic. Failure to act swiftly at the required scale and across all affected communities and populations will result in more HIV transmissions, more HIV-related morbidity and mortality, continued health inequities, and increased health care costs.

Through the joint effort of community, all levels of government, and industry, we can harness the progress made over the last three decades to achieve a once unthinkable goal. Experience and research show us that a focus on the six pillars detailed below will provide the guidance, framework, and direction needed to drastically reduce new HIV cases, improve the length and quality of the lives of people living with HIV, and effectively address the related opioid, viral hepatitis, STI, and TB syndemics. In doing so, we can dramatically reduce overall costs in both lives and health care dollars.

## **Pillar 1: Commit to End the U.S. HIV Epidemic and Eliminate HIV Health Disparities**

To end the U.S. HIV epidemic, we must use all the powerful tools available, hold ourselves accountable for results, and ensure that no person or community is left behind.

### **Set Public Health Goals to End the U.S. HIV Epidemic by 2025**

Experience has demonstrated that time-bound public health goals drive progress, promote accountability, and unite stakeholders. We must set and meet benchmarks, modernize our national HIV surveillance system, and develop a real-time dashboard of key metrics to track the epidemic, gauge our progress, and better prioritize resources, if we are going to end the U.S. HIV epidemic.

Mathematical modeling, detailed starting on page 7 of this Roadmap, indicates that achieving the 95/95/95 HIV care framework by the year 2025, coupled with PrEP scale-up, will significantly reduce HIV incidence and prevalence in the U.S.

Compared with the scenario of simply continuing current efforts:

- Achieving the 95/95/95 care framework and 40 percent PrEP coverage by the year 2025 would have the greatest impact on HIV incidence and prevalence, reducing the number of new HIV cases occurring during the years 2019 to 2030 by approximately 353,000 persons.
- Achieving the 95/95/95 framework by the year 2030 would reduce the number of new HIV cases occurring during the years 2019 to 2030 by approximately 210,500 persons. Increasing uptake of PrEP to achieve 40 percent coverage of persons vulnerable to HIV would further amplify these gains, bringing the total of averted new HIV cases between now and 2030 to 292,500 persons.

***Achieving the 95/95/95 care framework and 40 percent PrEP coverage by... 2025 would have the greatest impact on HIV incidence and prevalence.***

Additional resources will be required to achieve these programmatic service delivery goals. Without such rapid scale-up, however, the U.S. HIV epidemic will continue to outrun the response, increasing the long-term need for HIV treatment and dramatically raising future costs. Indeed, public spending on accelerated scale-up will generate historic health benefits and savings sufficient to offset or exceed the required investments. Modeling indicates that the decreased occurrence of new HIV cases that would result from achieving the 95/95/95 HIV care framework by 2025 would reduce public spending on HIV medical treatment costs by at least \$57 billion. This money could be better used between now and 2030 to fund the care and services needed to prevent new HIV cases, stop HIV-related deaths, and end HIV-related health disparities. Investment now would make history by ending the U.S. epidemic and still be considered cost-saving.

**... achieving the 95/95/95 HIV care framework by 2025 would reduce public spending on HIV medical treatment costs by at least \$57 billion.**

### **Recommendations for action:**

- Set concrete public health goals and benchmarks to end the U.S. HIV/AIDS epidemic by the year 2025 by dramatically reducing new cases, optimizing health for all persons with HIV, and ending AIDS deaths.
- Modernize our national HIV surveillance system and develop and monitor actionable metrics in real time to track the epidemic, gauge progress, and ensure that no community or geographic region is left behind.
- Partner with community to expand the AHEAD dashboard, make those local, state, and U.S. territory goals and benchmarks publicly available, and update them annually to show progress.

### **Eliminate U.S. HIV-Related Health Disparities**

To truly end the U.S. epidemic, we must not only achieve these public health goals in absolute terms, but also in a manner that addresses persistent disparities in HIV risk and health outcomes by focusing efforts and increased resources on communities that bear the greatest burden of the epidemic.

Social and economic marginalization leaves certain communities to bear the brunt of the U.S. epidemic. Black and Latinx<sup>2</sup> gay, bisexual, queer, and other men who have sex with men (MSM), cisgender Black and Latinx women, and trans-identified and gender nonconforming women continue to be disproportionately affected by HIV, especially in the Deep South, rural and suburban areas in the Midwest, and urban centers in California and the Northeast. Many recent immigrants are afraid to access HIV prevention and medical care out of fear of deportation or that the proposed expansion of the “public charge” definition will bar their applications for citizenship, which has the potential to dramatically increase new HIV cases among Latinx gay and bisexual foreign-born men.

The U.S. HIV epidemic also differs dramatically by region and state, with some epidemics concentrated in urban areas and others more widely dispersed. According to the CDC, “the South now experiences the greatest burden of HIV infection, illness, and deaths of any region in the United States, and lags far behind in providing quality HIV prevention and care to its citizens.”

Stigma in all its manifestations also plays a significant role in perpetuating the U.S. HIV epidemic. Stigma related to age, race, gender, gender identity, sexual orientation, substance use, and HIV itself may discourage people from getting tested for HIV and from accessing and engaging in prevention and treatment services.

---

<sup>2</sup> “Latinx” is the gender-neutral form of “Latino/Latina.” <https://www.merriam-webster.com/dictionary/Latinx>

As detailed further in the Roadmap, the tools of HIV testing, care, treatment, and prevention are evidence-based and well-described. However, to impact the U.S. epidemic they must be offered in a manner that directly addresses the social and structural determinants of pernicious HIV health disparities.

Recommendations for action:

- The CDC must create new, additional targeted funding opportunities for community-based organizations (CBOs) outside the large metropolitan areas, particularly in the U.S. South and in small cities with high rates of incidence and mortality.
- The CDC and the Health Resources and Services Administration (HRSA) should seek ways to support non-traditional clinics such as point-of-care services, mobile clinics, telemedicine facilities, and integrated medical care in other social support service settings to increase access points for vulnerable populations and communities disengaged from the health system.
- Upgrade treatment and prevention services in Puerto Rico, the U.S. Virgin Islands, and all territories to the level achieved across the mainland while ensuring representation and leadership by the territories.
- HRSA should examine the feasibility of distribution of Ryan White Program Part B Supplemental Funding that takes into account the disproportionate impact of HIV incidence and outcomes in the U.S. South and other areas with emerging needs and should increase funding for the program.
- HHS agencies must fund HIV-related stigma reduction interventions, health literacy, and health system navigation services, with particular efforts to prioritize communities of color and the U.S. South and expand awareness of and access to PrEP.
- Strengthen protections from discrimination for lesbian, gay, bisexual, and transgender people under both Title VII of the Civil Rights Act and Title IX of the Education Amendments Act of 1972 and provide better reporting on the health and human services needs of the entire LGBTQ community with a particular emphasis on the transgender community.
- Reject changes to the “public charge” definition that would deter immigrants from seeking health care, including preventive health services, for themselves and their families.
- Establish and resource a cross-governmental working group to address issues related to an aging population living with HIV inclusive of inflammation, social isolation, multiple morbidity, polypharmacy, and the need to emphasize maintenance of function.

***Ending the HIV epidemic in the U.S. relies on a robust integrated health care system and equitable access to comprehensive health care coverage for people living with and vulnerable to HIV.***

## **Pillar 2: Ensure Broad and Equitable Access to Effective HIV Care and Treatment**

To sustain optimal health for people living with HIV and stop ongoing transmission, we must maximize the number and proportion of people with a suppressed HIV viral load as rapidly as possible following diagnosis by ensuring effective, high quality HIV care that leaves no one behind.

Ending the HIV epidemic in the U.S. relies on a robust integrated health care system and equitable access to comprehensive health care coverage for people living with and vulnerable to HIV. An estimated 56 percent of people living with HIV count on Medicaid, Medicare, or both for their health care coverage, an estimated 30 percent are covered through private insurance, and 14 percent are uninsured. The Ryan White HIV/AIDS Program

covers 52 percent of all people living with HIV in the U.S., and, as a non-insurance payer of last resort, fills in payment gaps for people living with HIV who are also enrolled in Medicaid, Medicare, and/or private insurance.

In terms of federal expenditures, Medicare is the largest federal funder of HIV care and treatment at \$10 billion per year, followed by Medicaid at \$5.9 billion, and then the Ryan White HIV/AIDS Program at \$2.3 billion. Further, Medicaid expansion and private insurance reforms under the ACA have allowed tens of thousands of people living with and vulnerable to HIV to access comprehensive, affordable coverage for the first time. The commitment to and innovative use of state and local resources to fill gaps and cover costs excluded by federal funding streams is also vital.

## **Sustain and Expand Vital Health Insurance Programs**

Equitable, sustained access to adequate health coverage is the fundamental building block for ending the U.S. HIV epidemic:

- Medicaid is the largest source of insurance coverage for people with HIV, estimated to cover more than 40 percent of people with HIV in care.<sup>3</sup> Expanded and sustained access to Medicaid coverage across the country, as defined by the ACA, must be a top priority if we are to end HIV as an epidemic. This means protecting and expanding Medicaid as a health care safety net program in every state, ensuring the stability of the Medicaid program, and rejecting state proposals that would harm people living with HIV, such as rolling back benefits, restricting access for lifesaving medications, imposing work requirements as a condition of continued coverage, or requiring additional cost-sharing beyond the federal limits on low-income beneficiaries.
- The Medicare program is also a critical resource for ending the epidemic, covering 20 percent of people living with HIV in care. Most people with HIV on Medicare are under age 65 and qualify as disabled beneficiaries, and a significantly higher percentage of them are dually-eligible for Medicaid than in the overall Medicare population. With the implementation of the Medicare Part D prescription drug benefit in 2006, Medicare assumed an even more critical role for people living with HIV: Seventy-seven percent of Medicare beneficiaries living with HIV qualify for Part D prescription drug subsidies.
- The ACA's consumer protections that include prohibiting insurers from denying coverage due to pre-existing conditions, premium setting based on community rating, nondiscrimination protections, guaranteed coverage of essential health benefits, premium and cost-sharing assistance, and annual caps on out-of-pocket costs are all critical to improving access to health care coverage and services for people with HIV and must be maintained.
- Ensuring that people living with HIV can get the care their doctors prescribe requires that all public and private health insurance plans include consumer protections for prescription drug access and cap covered out-of-pocket prescription drug costs.

*In terms of federal expenditures, Medicare is the largest federal funder of HIV care and treatment at \$10 billion per year, followed by Medicaid at \$5.9 billion, and then the Ryan White HIV/AIDS Program at \$2.3 billion.*

### **Recommendations for action:**

- Ensure access to ACA-expanded Medicaid for people living with and vulnerable to HIV in all states, and oppose any measures aimed at limiting access to Medicaid.

---

<sup>3</sup> <https://www.kff.org/hiv/aids/issue-brief/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv/>

- Support implementation of innovative care delivery and payment models through state Medicaid programs, such as coordinated, integrated patient-centered health care programs, incentivize Medicaid programs to enter into data-sharing agreements with state and local departments of health, and require Medicaid programs to adopt HIV viral load suppression performance measures.
- Eliminate the 29-month waiting period before SSDI recipients can obtain Medicare benefits.
- Maintain in the Medicare Part D Formulary an “all drugs, all classes” rule for FDA-approved antiretroviral drugs.
- Extend Medicaid drug rebates to Medicare plans covering dually-eligible, low-income beneficiaries.
- Direct the Center for Medicare deputy administrator to ensure that beneficiaries have access to and a choice of providers, including pharmacies, and prohibit Part D plans from changing pharmacy networks mid-year to ensure continuity of care and treatment.
- Take all necessary legislative action to ensure that the ACA continues in full, including the nondiscrimination protections, and to stabilize the ACA insurance marketplace with sufficient funding for enrollment and marketing activities.

## **Enhance the Ryan White HIV/AIDS Program**

The federal Ryan White HIV/AIDS Program provides comprehensive services for the most vulnerable people living with HIV in the U.S. Almost two-thirds of Ryan White Program participants are living at or below 100 percent of the Federal Poverty Level (FPL), and over 90 percent are living at or below 250 percent of the FPL. Racial and ethnic minorities in every congressional district make up nearly three-quarters of Ryan White Program participants.

About 80 percent of all Ryan White Program participants are covered by some form of health care insurance, including about half who are covered by Medicaid and/or Medicare. However, public and private insurance programs do not always provide the comprehensive array of services required to meet the needs of people living with HIV. These include case management, mental health and substance use treatment, adult dental services, and transportation, legal, and nutritional support services.

***About 80 percent of all Ryan White Program participants are covered by some form of health care insurance, including about half who are covered by Medicaid and/or Medicare.***

The Ryan White Program, particularly the AIDS Drug Assistance Program, assists with these costs so that low-income people living with HIV can access comprehensive and effective medical care and treatment. To improve the continuum of care and progress toward an end to the U.S. epidemic, continued and enhanced funding for all parts of the Ryan White Program is crucial. Robust funding for the Ryan White Program is particularly important to fill gaps in health coverage for people with HIV in jurisdictions that have not expanded Medicaid, such as several states in the U.S. South.

### **Recommendations for action:**

- Increase funding for the Ryan White Program consistent with a growing epidemic and need, ensuring that the program’s funding formulas and structure support integrated efforts to end the HIV epidemic.
- Allow Ryan White Program-funded clinics access to health center reimbursement mechanisms under Medicaid.
- Create flexibility under program income guidance to ensure critical support for HIV services.
- Reduce renewal of benefits paperwork and, with new resources, train and hire more HIV care providers to reduce delays in linkage to care/ARV prescription.

## Protect the 340B Drug Pricing Program

Similarly, since 1992 the 340B Drug Pricing Program has provided critical support for HIV services and extends care to many who otherwise would go without. Savings from 340B allow covered entities, including AIDS service organizations, to increase health care services and capacity in their communities, offering more health care delivery locations and hours of operation and an expert workforce. Thanks to the savings covered entities earn through the 340B program, Americans living with and vulnerable to HIV benefit from lifesaving treatment, preventive health care, substance use and mental health services, and chronic disease management.

### Recommendation for action:

- Maintain the 340B Program to ensure critical support for HIV services.

## Adopt National Strategies to Eliminate Viral Hepatitis, STIs, and Tuberculosis

Sustaining the health of people with and at risk of HIV also requires concrete action to stop the worsening syndemics of viral hepatitis and tuberculosis (TB). People living with HIV are disproportionately affected by viral hepatitis—about one-third are coinfecting with either hepatitis B virus (HBV) or hepatitis C virus (HCV)—and HIV coinfection more than triples the risk of liver disease, liver failure, and liver-related death from HCV. With new highly effective curative treatments for HCV and treatment and a vaccine for HBV, we have the means to eliminate viral hepatitis as a public health threat in the United States. The risk of developing TB from latent infection is also significantly increased for people living with HIV, and TB is the leading cause of death for people living with HIV globally. Decades of declines in federal and state funding for TB prevention and control have led to the deterioration of public health infrastructure and limited the capacity of TB programs to provide prevention, treatment, and monitoring efforts and to prevent and respond to outbreaks, especially to emerging drug-resistant strains. TB is preventable, treatable, and curable, but putting the U.S. back on the track of TB elimination will require national leadership, resources, and political will.

*People living with HIV are disproportionately affected by viral hepatitis... and HIV coinfection more than triples the risk of liver disease, liver failure, and liver-related death.*

### Recommendations for action:

- Fully implement and resource the National Viral Hepatitis Action Plan 2017–2020 and establish, implement, and resource the Viral Hepatitis National Strategic Plan 2021–2025.
- Support local, state, and national TB elimination efforts, including implementing and resourcing the National Action Plan to Combat Multidrug-Resistant TB.
- Fully implement and resource the Sexually Transmitted Infections National Strategic Plan for the U.S. 2021–2025.

## Pillar 3: Prevent New HIV Transmissions

While we work to diagnose and treat all Americans living with HIV, we also must work to prevent exposure. We know that biomedical, behavioral, and structural interventions used in concert can successfully and significantly reduce HIV transmission. Routine and voluntary universal HIV testing is a gateway to HIV prevention for those who test negative; effective treatment for people living with HIV suppresses viral load to undetectable levels,

eliminating sexual transmission. Both groups benefit from interventions to address behavioral and structural factors that increase the risk of acquiring and transmitting HIV.

However, there are still an estimated 40,000 new cases in the U.S. each year, and while rates of new cases are declining in some communities, there are increases or no change in communities where resources for prevention and care are limited. The Southern U.S. is particularly affected, accounting for over 50 percent of the estimated new cases while representing only 37 percent of the U.S. population.

## **Reduce New HIV Cases Through Evidence-Based Combination HIV Prevention Strategies**

HIV prevention services must be comprehensive and include high quality, medically accurate, age appropriate, culturally responsive, HIV, reproductive, and sexual health education at all levels; truly routine screening for HIV for all persons over age 15 as preventive care; broad and equitable access to pre-exposure prophylaxis (PrEP) for those vulnerable to HIV; wide access to non-occupational and occupational post-exposure prophylaxis (PEP); syringe access and other harm reduction services as needed by people living with HIV and HIV-negative persons; and insurance coverage of HIV prevention, including PEP and PrEP, as essential preventive health care services.

### **Recommendations for action:**

- The CDC and HRSA should create tools to support providers' deployment of key messaging and training on the use of prevention tools and interventions, including launching a widespread "Undetectable Equals Untransmittable" (U=U) social marketing campaign.
- Expand routine HIV testing for all Americans, including by reviewing and relaunching the CDC recommendation that everyone should be tested at least once, and increase CDC funding streams for age-specific, innovative outreach and testing.
- Through CDC and HRSA, provide support for primary trainings and continuing education for providers in cross-cutting cultural responsiveness.
- Ensure the availability and affordability of PrEP across all populations through a combination of federal funding, addressing pricing issues for commercially available PrEP already on the market, and investing in development of new PrEP modalities.
- Support sexual health education programs by increasing funding for existing programming for adolescents, such as the CDC's HIV School Health efforts through the Division of Adolescent and School Health (DASH), the Teen Pregnancy Prevention Program (TPPP) through the Office of Adolescent Health, and an extension of the Personal Responsibility Education Program (PREP); eliminating federal funding for abstinence-only-until-marriage programs, including the Title V Sexual Risk Avoidance Education state-based grant program; and requiring that all federally-funded state juvenile detention, foster care, and mental health facilities for youth include sexual health care and literacy in their services.
- Support both the Real Education for Health Youth Act (REHYA) and the Youth Access to Sexual Health Services Act (YASHS).
- Protect and bolster funding for providers of sexual and reproductive health care, especially through the Title X Family Planning Program.
- Fund community-based HIV service organizations to provide COVID-19 testing to increase local usage of ASO/CBOs and to potentially increase HIV testing among people who are traditionally missed by testing efforts.

***HIV prevention services must be comprehensive and include high quality, medically accurate, age appropriate, culturally responsive, HIV, reproductive, and sexual health education at all levels***

## Stop the Opioid, Injection Drug, and Crystal Meth Use Crises

The overdose crisis and attendant increases in injection drug use are driving a significant increase in the rate of new viral hepatitis infections and threatening to reverse the substantial gains since 1990 in reducing HIV rates among people who inject drugs. In addition, many jurisdictions around the country have reported spikes in methamphetamine use. Community-based harm reduction, overdose prevention, and syringe services programs have consistently demonstrated the greatest impact and are the most cost-effective interventions available to reverse the overdose and infectious disease crises devastating our communities. Widespread, free, and low-barrier access to all forms of Medication Assisted Treatment (MAT) for those who seek it must be a critical component of federal, state, and local strategies to address the opioid epidemic.

### Recommendation for action:

- Develop, implement, and resource a National Harm Reduction Strategy with particular focus on overdose and infectious disease prevention (recommendations are detailed in this Roadmap starting on page 58), ending criminalization and promoting the rights and dignity of people who use drugs (recommendations are detailed in this Roadmap starting on page 61), and structural interventions and social determinants of health (recommendations are detailed in this Roadmap starting on page 63).

*Widespread, free, and low-barrier access to all forms of Medication Assisted Treatment (MAT) for those who seek it must be a critical component of federal, state, and local strategies to address the opioid epidemic.*

## Reduce the Syndemic of Sexually Transmitted Infections

The U.S. is experiencing a historic rise in rates of sexually transmitted infections (STIs)—another indication of a public health infrastructure continually strained by budget reductions at every level of government. More than 2 million cases of chlamydia, gonorrhea, and syphilis were reported in 2016, the highest number ever recorded.

Investment in comprehensive STI prevention, testing, treatment, and research must be an essential component of our comprehensive HIV prevention strategy and is critical to ensuring that individuals can remain healthy, active participants in our workforce and society.

### Recommendations for action:

- Fund STI prevention at a level commensurate with the scope of the epidemic.
- Include STI screening and treatment as a component of HIV prevention programs.
- Invest in comprehensive education for providers about the need for three-site testing, culturally responsive language, and methods for eliciting full sexual histories.
- Fund epidemiological and implementation research to determine the scale of crystal meth use among Black and Latinx MSM and transgender women, as well as potential biomedical, behavioral, and structural harm reduction approaches.

## Pillar 4: Address Social and Structural Barriers to Effective HIV Prevention and Care

Biomedical treatment and prevention alone will not end the U.S. HIV epidemic. Structural factors including poverty, discrimination, lack of employment and educational opportunities, housing and food insecurity, untreated or undertreated mental health and substance use challenges, and limited transportation infrastructure contribute to poor health outcomes. Other structural contributors to the U.S. HIV epidemic include the criminalization of HIV nondisclosure, exposure, and/or transmission, nonviolent drug violations, and adult consensual sex work; interpersonal violence; the burden of disproportionate incarceration and entanglement with the criminal justice system for young men of color and transgender persons; and barriers to prevention and care services for new immigrants. For many persons living with or vulnerable to HIV, successful prevention and care requires culturally competent services to address these barriers, and evidence demonstrates that interventions to ensure adequate housing, food, transportation, and other critical enablers of health care are both essential and cost-effective.

### ***Ensure Availability of Essential Services That Support Health, Prevention, and Retention in Care and That These Services Integrate the Innovations That Resulted from COVID-19***

The federal government has a unique opportunity and responsibility to expand efforts to assure availability of essential services that support health, HIV prevention, and retention in care, including programs that address poverty, unemployment, criminal justice involvement, and other social factors that drive the ongoing U.S. HIV epidemic, as well as programs and supports that address homelessness, hunger, and other unmet subsistence needs that are powerful barriers to effective HIV care and treatment.

***Additionally, the innovation to HIV treatment and care that was introduced as a result of COVID-19 must continue to evolve even after the pandemic is under control.***

This includes the need to address disparities in health care and other structural drivers of the HIV epidemic across U.S. regions and communities.

Additionally, the innovation to HIV treatment and care that was introduced as a result of COVID-19 must continue to evolve even after the pandemic is under control. This includes increased and uninterrupted access to telemedicine, greater supplies of prevention or treatment medication, swifter prescription refill times, syringe exchange, as well as HIV prevention/treatment medication delivery.

#### **Recommendations for action:**

- Fund the HUD Housing Opportunities for People with AIDS (HOPWA) program at levels commensurate with the epidemic and increase federal investments in the Housing Choice Voucher program and other HUD-administered Permanent Supportive Housing programs.
- Eliminate eligibility restrictions to accessing HUD programs related to drug use or drug-related convictions.
- Reject the imposition of work requirements, drug screening, or other barriers to food security programs across the government including the Supplemental Nutrition Assistance Program.
- A federal interagency task force composed of National HIV/AIDS Strategy implementers including HHS, HOPWA, Department of Labor, and Department of Education should develop a plan to support the vocational training and employment of people with HIV.
- Department of Justice and HHS must collaborate and provide resources to states and localities to prevent and treat HIV during incarceration and upon reentry, as well as to improve HIV testing, prevention, and treatment services in federal prisons.

## Provide Federal Leadership to End HIV Criminalization

Laws that criminalize HIV exposure, non-disclosure, transmission, and behaviors that can transmit HIV, despite evidence that this does not impact HIV transmission, are systemic structural barriers that create stigma and discrimination and infringe on the civil rights of people living with HIV.

It is time to eliminate HIV-specific and -related laws that are outdated, do not reflect current scientific understanding, and are at odds with well-tested and effective public health strategies.

### Recommendations for action:

- Support and pass legislation to end HIV criminalization via the REPEAL (Repeal Existing Policies that Encourage and Allow Legal) HIV Discrimination Act.
- Decriminalize sex work.
- Repeal the Stop Enabling Sex Traffickers Act (SESTA) and the Allow States and Victims to Fight Online Sex Trafficking Act (FOSTA) and pass anti-trafficking legislation that does not conflate human trafficking with consensual adult sex work.
- With community input, review the uses of HIV molecular surveillance and the research on its efficacy in helping reduce transmissions, and create and publish guidelines restricting the access local, state, and federal policing and law enforcement agencies have to said data.

*It is time to eliminate HIV-specific and -related laws that are outdated, do not reflect current scientific understanding, and are at odds with well-tested and effective public health strategies.*

## Pillar 5: Maintain U.S. Leadership in Lifesaving Research

In the last four decades, HIV/AIDS research has been responsible for the dramatic transformation of HIV from a uniformly fatal diagnosis to one that can be managed over a near-normal lifespan. Innovations such as highly effective antiretroviral therapy and PrEP combined with strategies to address health disparities and structural drivers give us the tools to bring HIV below epidemic levels in the U.S. However, additional research advances will support maximizing the implementation of existing tools and developing new modalities to sustainably end the HIV epidemic in the U.S. and worldwide.

As such, a robust research agenda is an indispensable part of our ability to end the domestic and global epidemics. The federal government must support groundbreaking research within the National Institutes of Health and other publicly-funded research bodies to develop a preventive vaccine, microbicides, a cure for HIV, new HIV treatments, new approaches to PrEP, and implementation science to support scaling up treatment and prevention, including by addressing co-morbidities and related health disparities.

### Recommendations for action:

- Make sustained, multi-year increases to HIV/AIDS biomedical research in line with reaching the Office AIDS Research (OARs) annual Professional Judgement Budget recommendations.
- Increase resources for other HIV/AIDS research activities, including implementation science, across all levels of government; leverage the Centers for AIDS Research (CFAR) national network to enhance collaboration with local AIDS service organizations and community-based organizations to support implementation science within communities; and continue existing HIV research cohorts.

- Expand ethical research on treatment, prevention needs, and implementation among vulnerable populations such as youth, people of color, pregnant and lactating women, people of trans experience, and people who use drugs.
- Establish a federally-supported Structural Interventions Research Committee within the Office of AIDS Research to advance coordination, communication, and furthering of cross-government research.
- Use existing mechanisms to recruit and train new HIV investigators, especially from the most impacted and underrepresented communities.

## **Pillar 6: Support the Meaningful Involvement of People Living with and Vulnerable to HIV**

No complex health crisis can be resolved without the leadership of affected communities and centering vulnerable individuals within the heart of the response.

The communities and constituencies affected by HIV/AIDS across the United States, Puerto Rico, U.S. Virgin Islands, and all other territories include people living with HIV/AIDS, people of color, transgender and cisgender women and men, queer-identified and gender nonconforming individuals, sex workers, immigrants with and without documentation, people in U.S. jails, prisons, and immigration detention centers, people who use drugs, people living with mental health challenges, people living with physical and intellectual disabilities, people of all religious practices, all languages, all ages, and in all regions. Many daily confront stigma, transphobia, homophobia, unemployment, economic and food insecurity, homelessness, lack of health care, violence, discrimination, criminalization, racism and white supremacy, and, as a result, struggle with self-determination, political participation/inclusion, safety, and equality before the law. Many work to organize, mobilize, and empower the communities they serve—not only to end the HIV epidemic but also to eliminate the structural barriers and vulnerabilities that keep our resilient communities from living fully and with dignity.

The resilience, wisdom, and agency of affected communities must guide the implementation of any national plan to end the HIV epidemic in the U.S. Policymaking to end the epidemic must prioritize opportunities to uplift voices and provide clear paths for leadership by those most marginalized and affected by the epidemic.

*The impact of COVID-19 on public health and health care systems stalled many HIV prevention and treatment programs around the country and strained the capacity of the public health workforce as well as its resources.*

### **Recommendations for action:**

- Ensure equity in allocation of human, material, and financial resources when implementing the actions recommended in this Roadmap.
- Center the communities most impacted by the epidemic in leadership and decision-making when crafting policies and solutions in any and all efforts to end the epidemic.

## Conclusion

We have made substantial progress in responding to the HIV epidemic. At the beginning of the epidemic, no one could have predicted the incredible success of antiretroviral medications that today permit people with HIV to live healthy, productive, and long lives. In the last decade, the U.S. has created and implemented the first National HIV/AIDS Strategy, launched a federal End the HIV Epidemic plan, developed antiretroviral prevention technologies like PrEP and treatment as prevention, implemented more syringe services programs, made science-based sexual and reproductive health education available to additional young people, and improved access to health care for millions of Americans.

At the same time, we are now met with unforeseen challenges. The impact of COVID-19 on public health and health care systems stalled many HIV prevention and treatment programs around the country and strained the capacity of the public health workforce as well as its resources. The ongoing uprisings in many cities in response to police violence against Black people and efforts by the Trump Administration to undermine LGBTQ protections, separate immigrant children and families at the border, and give tacit approval to armed white nationalist organizations—coupled with confusing and often inaccurate information on COVID-19 testing and treatment—have fueled public mistrust of government institutions. This environment of mistrust and suspicion can prevent people from accessing the best HIV prevention and treatment available, making efforts to end the epidemic increasingly difficult. However, we are hopeful that these challenges are not insurmountable, and that lessons learned from the current moment will help transform HIV prevention, treatment, and care—and public health more broadly—for the better, for the future of the nation.

*Implementing this roadmap to end the HIV epidemic in the United States is possible only with decisive action from Congress and the Administration.*

Even with these challenges, the U.S. has the capability to reverse and potentially end the domestic epidemic. The HIV community, in collaboration with state and local jurisdictions, is working to implement plans to do so. As is clear from the recommendations made here, the support and intervention of the federal government will be central to ending the epidemic across the U.S. Only by prioritizing the needs of people with HIV, addressing health disparities, preventing new cases, improving the health care system, creating structural mechanisms to improve health outcomes through ancillary services, and producing groundbreaking, cross-cutting research can we come together to defeat one of the most complex viruses ever encountered.

**Implementing this roadmap to end the HIV epidemic in the United States is possible only with decisive action from Congress and the Administration. We must officially declare a goal to end the epidemic by 2025, and the time to make this declaration is now. Consequently, the undersigned call on the U.S. government to officially declare that it is our goal to end the HIV epidemic in the United States by 2025 and to enact legislative and regulatory changes to achieve this goal.**