December 9, 2009

President Barack Obama
The White House
Washington, DC 20500

Dear Mr. President,

As you know, HIV/AIDS remains a public health emergency in the United States. There is a new HIV infection every 9 ½ minutes, half of people living with HIV/AIDS are not in care, and there are disturbing and persistent gender, racial, ethnic, and geographic disparities in HIV infection rates and treatment access.

Despite these challenges, we have ample evidence that HIV prevention strategies are effective and have already averted hundreds of thousands of HIV infections in the US. With your leadership and commitment to implement a new, coordinated plan of action, a dramatic reduction in HIV infections in the U.S. is possible.

As individuals dedicated to ensuring the most effective response to HIV/AIDS in our country, we thank you for your pioneering leadership on health reform. We know that health reform will have a profoundly positive impact on the lives of people living with and at elevated risk of HIV/AIDS. Still, health reform will not solve all the complex issues involved in vulnerability to HIV infection or utilization of HIV-related health care.

We therefore applaud your commitment to developing a National HIV/AIDS Strategy designed to create an efficient and accountable federal HIV prevention and care effort that is focused on achieving specific outcomes: bringing down HIV incidence, increasing care access, and reducing health disparities.

We are 34 national leaders in HIV programming and policy who came together in October 2009 to discuss how the Strategy can lead us to the most effective HIV prevention effort. This independent meeting was sponsored by the Coalition for a National AIDS Strategy to complement the series of community discussions organized by your Office of National AIDS Policy (ONAP). The Coalition is organizing three other independent consultations on aspects of the Strategy: care, disparities and research.

Mr. President, to achieve your laudable goal of lowering HIV incidence, **your Strategy must bring about fundamental changes in federal HIV prevention efforts**, including:

- **Greater priority on prevention** in the US response to HIV/AIDS, and substantially **increased resources** for prevention
- True **accountability and results-oriented management** that includes a limited number of distinct, ambitious and achievable targets and regular reporting on results
- A **strategic orientation** that evaluates national, state and local programming for its ability to achieve population level impact on incidence and monitors resource allocation to ensure prevention funds are used to achieve maximum impact
- **Coordination across multiple federal agencies** engaged in HIV prevention
- **New targeted initiatives** designed to meet the HIV prevention needs of: 1) gay/bisexual men of all races, other men who have sex with men (MSM) and transgender people of all races and ethnicities; and, 2) Black women and men, inclusive of Black MSM
- **Long term investments**, such as Health Renewal Zones, to **address antecedents of risk** that facilitate HIV and other health disparities including STI, hepatitis and tuberculosis transmission in the most vulnerable communities

Without concrete changes in our nation's approach, there is the very real danger that HIV prevention efforts will actually deteriorate in the coming years, leading to increasing HIV incidence. Severe cutbacks in state budgets have already undercut health promotion programming across the country. We need a much more strategic, accountable and better-funded federal HIV prevention enterprise than we have had to date, as well as your ongoing, personal leadership to demand improved outcomes from public and private programming.

Perhaps the most salient agreement forged at our recent consultation was the moral imperative of a bold undertaking to address the domestic HIV/AIDS crisis with the full force and influence of the federal government. Our consultation generated many good ideas, but we want to highlight a few core points that we believe are essential to creating a Strategy that will advance our nation's HIV prevention response and lead to lower HIV incidence rates:

1) Set ambitious, achievable targets for reduced HIV incidence and a limited number of other HIV prevention-related goals and ***report annually on progress*** **towards achieving these targets.**

The current CDC target of reducing HIV incidence by 5% annually is not sufficiently ambitious. Setting a goal for more rapid progress towards lower HIV incidence will send a clear message that your Strategy is designed to bring needed improvements in our HIV prevention response. We recommend setting aggressive targets for *HIV incidence, the HIV transmission rate, HIV testing (including our success at diagnosing those who are HIV-positive), and the percentage of people who are living with HIV/AIDS and know their status*. We recommend **setting a federal goal of reducing the HIV incidence and transmission rates**[1] **by 50%** by the end of 2016. This goal can only be achieved given significantly increased resources and a more efficient and effective prevention effort.

2) Make needed reforms in the federal HIV prevention effort. These include:

- Significantly **increase resources for HIV prevention** at CDC and other agencies. HIV prevention programming has not seen a significant increase in years. New resource investments are needed commensurate with more ambitious targets for reduced incidence. The CDC's Professional Judgment Budget estimate of $1.6 billion needed for comprehensive HIV prevention should be used as a guide in determining funding requests.
  - Ensure *new prevention resources through health reform*, including Community Based Prevention and Wellness services, are available for HIV prevention.

- **Call for needed changes in law and policy** to advance HIV prevention and reduce stigma against PLWHA and groups perceived at elevated risk for HIV. Necessary legal changes include:
  - Ending the ban on *federal funding for syringe exchange*
  - Passage of the *Employment Non-Discrimination Act;* repeal of the *Defense of Marriage Act;* repeal of *restrictions on promotion of homosexuality* in HIV prevention materials*;* and repeal of *Don't Ask Don't Tell*.
  - *Reform of sentencing laws and creation of more options to avoid imprisonment* in order to reduce the number of individuals cycling in and out of the corrections system and the resulting impact on communities
  - Expanded funding for age-appropriate *comprehensive sex education that includes positive images of LGBT sexuality*.

[1] The HIV transmission rate represents the amount of transmission that occurs annually in relation to the population infected with HIV (technically, this is HIV incidence divided by prevalence in a given year).

- Establish a **more accountable and transparent** HIV prevention response:
    - Direct CDC and other agencies engaged in HIV prevention to publish an *inventory of where prevention funds are allocated*. Provide an analysis of how public funds are allocated to various functions in the public and private sectors.
    - Monitor local and state use of federal funds to *ensure resource allocations appropriately match* the epidemiology of local epidemics.
    - Direct CDC, NIH and other agencies to create a *resource allocation model* to help local and state planners prioritize resources among different levels of interventions for different epidemics (building upon CDC's initial efforts to construct such a model)
    - *Substantially transform the Community HIV Prevention Planning process* so that there is a more accountable and truly strategic response to local and state epidemics. Provide *flexibility in the HIV Prevention Community Planning process* by limiting federal requirements to jurisdictions to the demonstration of the meaningful input of people living with HIV/AIDS and allocation of resources closely informed by the epidemiologic profile (while allowing jurisdictional and state flexibility in demonstrating coherence with national strategic goals).
    - *Clarify that the CDC's Compendium of Evidence-Based HIV Prevention Interventions and Diffusion of Evidence-Based Interventions (DEBI) programs* are just two elements of the HIV prevention response. It is essential that prevention programming be founded on evidence of what is effective without discouraging innovation. A greater emphasis is needed on developing and testing scalable programs, as well as evidence-based programs to address prevention needs, particularly among populations at elevated risk, including young gay/MSM.
    - Put new emphasis on *evaluating innovative prevention programming that can be brought to a scale* capable of making population-level impact. This will require assuring that interventions are prioritized according to their ability to reduce incidence. The current paucity of research on what programs are effective at achieving population-level impact on HIV incidence is a major impediment to more successful prevention efforts.

- **Improve the quality and policy-relevance of HIV epidemiology**.
    - Revise the format of the annual CDC epidemiologic report so that it has *maximum relevance for national, state, and local planners*.
    - Create a *"dashboard" of critical epidemiological data* that can guide strategic planning and resource allocation; this would require *improved surveillance of HIV incidence* and would include disease incidence and

- behavioral data, coverage of HIV testing and other services, concurrent HIV and AIDS diagnoses and other measures. This is necessary to capture in one place multiple factors related to epidemic dynamics.
- *Study resiliency factors* of people living in environments with high incidence of HIV, STIs and other health conditions to better understand how people successfully avoid contracting HIV infection.

- **<u>Reform HIV prevention financing</u>**.
  - Provide local and state health authorities with *greater flexibility to synergistically use federal funds* across disease and program functions, to test innovative prevention approaches, and to better integrate HIV prevention into other prevention efforts.
  - Recognize and *address the lack of financing systems for critical functions* like routine testing, STI screening and other clinical prevention services, or for potential new prevention interventions including pre-exposure prophylaxis (PrEP) and the use of HIV treatment for HIV prevention. (These potential new interventions should augment, but not replace, core prevention strategies already operating at an insufficient scale.)
  - In creating your Strategy, consider *HIV prevention resources across federal agencies*, and consider how to use these resources to maximum impact.

- **<u>Coordinate HIV prevention work across federal agencies</u>**.
  - Establish regular *high-level inter-agency coordination meetings or calls* and *require federal agencies to provide specific examples of how they have improved coordination* to advance progress towards Strategy goals every six months.
  - Ensure that HIV is included in any national prevention strategy (developed as part of health reform legislation) that coordinates federal agency efforts on health promotion.
  - Encourage greater *coordination of resources* between CMS, HRSA, CDC, SAMHSA, NIH, VA, HUD and other agencies critical to HIV prevention.
  - Consider creating a *lead coordinating office for HIV prevention* (or the full HIV/AIDS response) across federal agencies. One option is to expand the role of ONAP so that it has more a more explicit program coordination role and more authority to coordinate agency efforts.

3) Implement interventions that will change the trajectory of the epidemic in the United States.

Accomplish immediate impact --

- Launch **<u>major initiatives to reduce incidence among groups that bear the greatest burden</u>** in the epidemic.
    - *Presidential initiatives are needed to address HIV among gay men, other MSM and transgender people of all races and ethnicities; and Black women and men.* These initiatives should be true strategies with their own targets and adequate resources for reaching their goals.
        - The initiative for Black women and men must help build sustainable infrastructure in Black communities; encourage development of prevention programming by these communities; integrate HIV testing, prevention, treatment and care services; and invest in encouraging the Black community to take increased ownership of the HIV epidemic in Black America.
        - One aspect of the gay/MSM/transgender initiative must be an effort to reduce homophobia, and should include statements from you personally.
    - Establish an *Office of LGBT Health at NIH and at HHS* to support and coordinate health research and programming for this population.
    - Expand *tailored prevention services to other populations at elevated risk* including incarcerated persons, Latinos, and women of color.

- **<u>Bring effective HIV prevention strategies to scale</u>** so they can achieve population-level impact. Too often effective interventions are not implemented widely enough to have measurable impact on incidence.
    - With what we know today, it is possible to virtually *eliminate HIV incidence among injection drug users*; a campaign utilizing syringe exchange, substitution therapy (e.g. methadone), and other program and policy approaches should be launched to accomplish this goal within five years.
    - *Scale up of prevention is needed with resources being allocated commensurate with incidence,* and among people living with HIV, gay/bisexual/MSM/transgender people, Blacks, Latinos, incarcerated persons, women of color and others.
    - Assure voluntary *HIV testing services are readily available*, particularly to people at elevated risk of infection

- o Determine whether a *Test and Treat strategy and/or pre-exposure prophylaxis* can be effective and cost-effective in reducing incidence.

Accomplish long term and sustainable impact --

- **Recognize and act on the social and structural factors that drive vulnerability** to infection.
  - o Through the Strategy process and using best practice methodologies, *conduct a systematic review of potential social drivers of the epidemic in our nation* (including poverty, lack of housing, imprisonment, marginalization of LGBT youth) and *recommend strategies to address the pathways through which these affect HIV incidence*
  - o Create *Health Renewal Zones*. Provide an array of behavioral, social and structural interventions for those structural factors which create vulnerability to HIV, other STIs and other health conditions. Include careful evaluation of the impact of these zones on HIV and other health outcomes over a five-year period. (This concept is consistent with Health Empowerment Zones proposed in House health reform legislation.)
  - o Consider establishing *primary prevention centers --* linked to clinical care, housing, employment, nutrition and other services -- where people in high impact communities can access a range of disease prevention services.
  - o Incorporate a *social justice approach to HIV prevention* by speaking out on issues of stigma and discrimination affecting PLWHA and those at risk, and develop programs that incorporate HIV prevention, including anti-stigma and discrimination components, into other services.
  - o Assure equal health rights for women, including *removal of limits on comprehensive reproductive services* through health reform legislation.
  - o Develop a comprehensive model of working closely with businesses and neighborhoods that have a role in preventing HIV and STDs, including the alcohol industry, internet sites, neighborhood based prevention services, and others

- **Rebuild our nation's public health infrastructure** so that it can provide HIV/AIDS and a range of health services to all who need them.
  - o Create a *Public Health Investment Fund* with a dedicated funding stream that will support state and local public health programs to reduce HIV incidence and empower individuals and communities to improve and protect their health.
  - o Design and implement a plan to *ensure access to and availability of HIV testing* and associated services in all areas of public health services in

order to reach disparate populations affected by HIV, including women and rural populations.
- Recreate programs such as the *Public Health Advisor Program* or similar programs proposed in health reform legislation to address critical workforce challenges across state and local public health agencies.

Mr. President, your Strategy is an exciting opportunity to refocus attention on the domestic HIV/AIDS epidemic and make dramatic progress in reducing HIV incidence in our nation. We look forward to working with you and your staff to create a much more coordinated, accountable, and outcomes-oriented response to HIV/AIDS at home. Please feel free to contact Chris Collins (chris.collins@amfar.org) and Julie Davids (jdavids@champnetwork.org) with any questions or comments about our ideas.

Sincerely,

Adaora Adimora, MD, MPH
UNC School of Medicine

Deborah Arrindell
American Social Health Association

Judith D. Auerbach, PhD
San Francisco AIDS Foundation

Cornelius Baker
National Black Gay Men's Advocacy Coalition

Douglas M. Brooks, MSW
JRI Health/Sidney Borum Jr. Health Center

Christopher Brown, MBA, MPH
Chicago Department of Public Health

Chris Collins, MPP
amfAR, The Foundation for AIDS Research

Kevin Cranston, MDiv
Massachusetts Department of Public Health

Don C Des Jarlais, PhD
Beth Israel Medical Center

Dazon Dixon Diallo, MPH
SisterLove, Inc.

Julie Davids
Community HIV/AIDS Mobilization Project (CHAMP)

Anna Ford
Urban Coalition for HIV/AIDS Prevention Services

Jennifer Hecht, MPH
STOP AIDS Project

Ernest Hopkins
San Francisco AIDS Foundation

David Holtgrave, PhD
Baltimore MD

Ronald Johnson
AIDS Action Council

Venton C. Jones Jr., MSHCAD
United Black Ellument (U-BE), UCSF – CAPS

Thomas M. Liberti
Florida Department of Health

Charles W. Martin
South Beach AIDS Project

Jean Flatley McGuire, PhD, MA
MA Executive Office of Health and Human Services

Jesse Milan, Jr., JD
Altarum Institute

David Ernesto Munar
AIDS Foundation of Chicago

Carl Schmid
The AIDS Institute

Julie M. Scofield
National Alliance of State & Territorial AIDS Directors

J. Walton Senterfitt, PhD, RN, MPH
Community HIV/AIDS Mobilization Project (CHAMP)

Ron Simmons, PhD
Us Helping Us, People Into Living, Inc.

William Smith
SIECUS

Ron Stall, PhD, MPH
University of Pittsburgh

Patrick Sullivan, DVM, PhD
Emory University

Dana Van Gorder
Project Inform

Vallerie D. Wagner, MS
AIDS Project Los Angeles

Craig Washington, MSW
AID Atlanta, Inc.

Phill Wilson
Black AIDS Institute

A. Toni Young
Community Education Group

* Institutions are listed for identification only.

Cc: Kathleen Sebelius, Secretary, Health and Human Services
Melody Barnes, Director, Domestic Policy Council
Jeff Crowley, Director, Office of National AIDS Policy
Helene Gayle, Chair, President's Advisory Council on HIV and AIDS