Presidential Advisory Council on HIV/AIDS (PACHA)

72nd Meeting (Virtual)
November 15 and 17, 2021

Council Members—Present
Marlene McNeese, PACHA Co-Chair, Deputy Assistant Director, Houston Health Department, Houston, TX (Day 1 only)
John Wiesman, Dr.Ph, 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
Juliet K. Choi, J.D., President and CEO, Asian & Pacific Islander American Health Forum, Washington, DC
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., Principal, Equity & Impact Solutions, Los Angeles, CA
Alicia Diggs, M.P.H., Manager, Office of Community Engagement, Center for AIDS Research, The University of North Carolina at Chapel Hill, Greensboro, 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
Jennifer Kates, Ph.D., Senior Vice President and Director of Global Health & HIV Policy, Kaiser Family Foundation, Washington, DC
Leo Moore, M.D., M.S.H.P.M., Medical Director for Clinic Services, Los Angeles County Department of Public Health, Los Angeles, CA
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
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 Sapero, Director, Ending the HIV Epidemic, Collaborative Research LLC, Phoenix, AZ
Carl Schmid, M.B.A., Executive Director, HIV + Hepatitis Policy Institute, Washington, DC
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

Council Members—Absent
Adrian Shanker, Founder and Executive Director, Bradbury-Sullivan LGBT Community Center, Allentown, PA

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 (CHAC)
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, Alternate Designated Federal Official; 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, Management Analyst, OIDP, OASH, HHS

Federal Partners
Laura Cheever, M.D., Sc.M., Associate Administrator, HIV/AIDS Bureau, HRSA (Day 2 only)
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
John W. Gilford, Ph.D., Regional Health Administrator, Region 4, OASH, HHS
Maureen M. Goodenow, Ph.D., Associate Director for AIDS Research, Director, Office of AIDS Research, National Institutes of Health (Day 1 only)
Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development
Timothy Harrison, Ph.D., Deputy Director for Strategic Initiatives and Senior Policy Advisor, OIDD, HHS
Heather Hauck, M.S.W., LICSW (for Laura Cheever, M.D., Sc.M.), HIV/AIDS Bureau, HRSA (Day 1 only)
Rick Havercate, 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 1 only)
Kristen Roha, M.S., M.P.H., Public Health Advisor for HIV, Substance Abuse and Mental Health Services Administration (SAMHSA)
Crystal Simpson, M.D., Medical Officer, Office of Medicare, Centers for Medicare & Medicaid Services (Day 2 only)
CAPT Samuel Wu, Pharm.D., Public Health Advisor, Office of Minority Health, HHS
Day 1

Opening Remarks from the PACHA Co-Chairs

Marlene McNeese and John Wiesman, Dr.PH., M.P.H., PACHA Co-Chairs

John Wiesman, Dr.PH., M.P.H., PACHA Co-Chair, called the meeting to order at 1:00 p.m. (This meeting was broadcast live online; the recorded broadcast is available online.)

Day 1 - November 15th
Part 1 https://youtu.be/NlqTeqDw_m0
Part 2 https://youtu.be/eDKdb-HGqso
Part 3 https://youtu.be/_5GWcZgaui8

Day 2 - November 17th
Part 1 https://youtu.be/u49lhQbhFxI
Part 2 https://youtu.be/77e7Uxr-roE
Part 3 https://youtu.be/n9d_4SN3Kqw

Marlene McNeese, PACHA Co-Chair, outlined the agenda for the meeting. She thanked HRSA for its work to enhance continuity of care and ensure access to care by clarifying policies around eligibility for the Ryan White HIV/AIDS Program, which will reduce administrative costs and burdens on clients. Ms. McNeese noted that PACHA aims to remain accessible to the communities most affected by HIV despite the pandemic restrictions preventing in-person meetings. Dr. Wiesman appreciated the engagement and input of community stakeholders.

Welcome

ADM Rachel L. Levine, M.D., Assistant Secretary for Health, HHS

Rachel L. Levine, M.D., noted that World AIDS Day (December 1, 2021) marks the 40th anniversary of the first reports of the disease eventually known as AIDS. She honored the memory of the 36 million people around the world who have died from AIDS and AIDS-related conditions and recommitted to serving the 38 million people with HIV (PWH) world-wide. ADM Levine said that ending the HIV epidemic requires increased and equal access to HIV services, meaningful engagements of community and civil society, and enhanced collaboration across all sectors of society and levels of government.

ADM Levine anticipated publication of the updated National HIV/AIDS Strategy (NHAS), which will reflect valuable input from agencies across HHS, PACHA members, and the public. One theme of the NHAS recommendations is the need to partner with agencies outside of HHS in recognition of the many social determinants of health (SDH) that affect the acquisition, spread, and consequences of HIV and threaten access to care and quality of life. As CDC Director Rochelle Walensky, M.D., M.P.H., stated, racism is a serious public health threat. Efforts to end HIV are complicated by structures that perpetuate stigma and discrimination and limit access to effective prevention, such as syringe services programs. The updated NHAS includes approaches to address inequity and SDH. ADM Levine said enthusiasm about the NHAS from various
Federal departments has been encouraging, and she looked forward to working with them and with PACHA to achieve the national goal of ending HIV.

ADM Levine offered updates on various OASH and OIDP initiatives around ending HIV. For example, OIDP added new data on SDH and HIV indicators to America’s HIV Epidemic Analysis Dashboard (AHEAD). OIDP teamed with the HHS Office of Minority Health to host a national competition, the HIV Challenge, which will fund efforts by individuals, organizations, and communities to combat HIV-related stigma, increase HIV prevention and treatment, and decrease racial and ethnic disparities around HIV. In addition, HHS’ Office of Population Affairs recently announced two grant competitions to support equitable, high-quality family planning services. The grants represent the first new funding since the Biden administration enacted rules that emphasize quality, equity, and dignity for all those seeking Title X services, reversing the restrictive changes to Title X made by the previous administration. HHS also released the new HHS Overdose Prevention Strategy in October, which highlights accelerating and amplifying access to proven treatments and interventions for overdose.

ADM Levine welcomed and administered the oath of office to two new PACHA members:

- Juliet K. Choi, J.D., President and CEO, Asian & Pacific Islander American Health Forum, Washington, DC
- Jennifer Kates, Ph.D., Senior Vice President and Director of Global Health & HIV Policy, Kaiser Family Foundation, Washington, DC

Nominations for new PACHA members are open through January 3, 2021.

Recognition of Former PACHA Members

John Wiesman, Dr.PH., M.P.H., PACHA Co-Chair

Dr. Wiesman thanked Wendy Holman, CEO and cofounder of Ridgeback Biotherapeutics, and Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), professor and head of dermatology at the Rutgers New Jersey Medical School, for their contributions and commitments to PACHA during their terms. Ms. Holman and Dr. Schwartz expressed gratitude for the opportunity to serve.

Roll Call

Ms. Hayes called the roll.

Message from the White House

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

Harold J. Phillips, M.R.P., explained that his office accelerated the process of updating the NHAS by building on the HIV National Strategic Plan, aligning the Strategy with Ending the HIV Epidemic: A Plan for America (EHE), and focusing on the immediate future (2022–2025). The updated NHAS will reflect the Biden administration’s priorities and recent research and detail the involvement of six Federal departments and 12 Federal agencies. Mr. Phillips thanked community stakeholders for gathering public input on the updated NHAS.
The revised NHAS reflects the call from the community and Federal partners to recognize the importance of health and well-being across the lifespan for PWH. The updated NHAS expands the vision by including diverse populations and focusing on increasing equity. The plan identifies nine core indicators to monitor national progress and establishes a new indicator to measure progress toward eliminating disparities in care. To develop a quality-of-life indicator, Mr. Phillips suggested convening a committee composed of Federal partners to explore national data sets and engage with the community for developing this indicator. Other indicators incorporate the EHE targets for reducing new infections and effects of stigma and disparities in care.

The updated NHAS emphasizes the need to engage people with lived experience of HIV in all phases of planning and decision making around HIV prevention, testing, and services. It focuses on overall quality of life for PWH, including a new focus on PWH who are aging. Additionally, the updated NHAS highlights the unique circumstances of populations at high risk of HIV that warrant specific attention and services, such as immigrants, people with disabilities, incarcerated people, homeless people, and sex workers. It places more emphasis on harm reduction and recognizes the syndemic of HIV, sexually transmitted infections (STIs), hepatitis, and substance use disorders. The updated NHAS underscores the vital role that the Patient Protection and Affordable Care Act (or the Affordable Care Act [ACA]) plays in the response to HIV. It identifies racism as a public health threat and calls for assessing how systemic and structural racism contributes to health disparities.

ONAP will work with Federal partners to develop implementation plans that align with the existing national strategies for viral hepatitis and STIs. ONAP will also engage non-Federal partners, including private-sector entities outside of the fields traditionally associated with health care. Mr. Phillips encouraged PACHA members and other stakeholders to become Champions for ACA Coverage and to continue to work to make the ACA more effective for PWH.

PACHA Subcommittee Reports

**EHE and the Updated National HIV Strategy**

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

John Sapero reported that the Subcommittee provided input for the updated NHAS. It addressed how the COVID-19 pandemic has hindered efforts to end HIV and lessons learned from COVID-19 responses that can be applied to improving HIV prevention and care. The Subcommittee discussed molecular HIV surveillance (MHS) to rapidly identify risk networks and potential outbreaks. These discussions informed the agenda for this meeting. The Subcommittee also addressed the role of PWH in the workforce, especially in leadership positions. At ONAP’s request, the Subcommittee met with experts to identify ways to increase private-sector engagement in EHE. As a result, the Subcommittee drafted a letter to HHS Secretary Xavier Becerra with suggestions for facilitating private-sector involvement, and this letter was discussed by PACHA at this meeting.
**Stigma and Disparities**  
*Rafaelé Narváez and Justin C. Smith, M.S., M.P.H., Co-Chairs*

Justin C. Smith, M.S., M.P.H., stated that the Stigma and Disparities Subcommittee also discussed MHS. This Subcommittee plans to convene a series of dialogues on MHS in 2022 and provide recommendations to PACHA on MHS at a future meeting.

**The Global Agenda**  
*Gregg H. Alton, J.D. Chair*

With the departure of Dr. Schwartz, Mr. Alton is seeking a new Co-Chair for the Subcommittee, as well as new members. The Subcommittee recognized the support of OIDP Senior Advisor Cedric Pulliam, Ph.D., and CAPT John Oguntomilade, Ph.D., M.P.H., B.D.S., director of the Prevention through Active Community Engagement program for Region IV, in evaluating the draft of the new President’s Emergency Plan for AIDS Relief (PEPFAR) strategy. Many of the comments on the PEPFAR draft addressed preexposure prophylaxis (PrEP). Mr. Alton said more consideration is needed about how to better communicate about PrEP and how to make it more accessible. The Subcommittee also plans to invite the new PEPFAR Ambassador At-Large to speak to the Subcommittee and PACHA when that person takes office.

**Perspectives on MHS**

**Molecular Data Use in HIV Cluster Detection and Response**

*Demetre Daskalakis, M.D., M.P.H., Director, Division of HIV/AIDS Prevention, NCHHSTP, CDC, and CAPT Alexa Oster, M.D., Acting Branch Chief and Medical Epidemiologist, Detection and Response Branch, Division of HIV/AIDS Prevention, NCHHSTP, CDC*

Demetre Daskalakis, M.D., M.P.H., emphasized that MHS is just one component of HIV cluster detection and response, a public health strategy critical to EHE. He pointed out that CDC will reach out to communities to explain how MHS and other tools are used and discuss how they can best be applied to end HIV. Cluster detection and response offers a framework for guiding tailored implementation of proven HIV prevention strategies in areas of rapid HIV transmission.

Rapid HIV transmission indicates that prevention and care efforts are not reaching those in need; therefore, cluster detection identifies populations or areas failed by the public health system. By identifying gaps and underserved populations, cluster detection enables tailored responses that address barriers and meet the needs of underserved populations. Cluster detection also identifies gaps in surveillance and can be used by Federal agencies and public health groups to steer at-risk individuals toward specialized interventions, such as PrEP or affordable housing. Rather than expecting individuals to adapt to standard services and resources, HIV prevention and detection efforts must adapt to meet the needs of underserved populations.

CAPT Alexa Oster, M.D., explained that clusters are detected through reporting from public health partners and routine analysis of HIV diagnosis surveillance data, which is particularly useful in areas with small populations or low burden of HIV. HIV molecular data usually come from drug resistance testing, and results are reported to public health agencies for secondary data analysis. Molecular testing for drug resistance yields a genetic sequence of the virus—not the individual—and this viral sequence is reported to the public health department, which transmits
it along with de-identified data to CDC. Consent for testing falls under the consent for care, and reporting is mandated by State and local laws.

Identifying clusters is crucial because transmission within clusters is much higher than among the general population. Cluster detection allows public health agencies to rapidly respond, including improving service availability and reducing onward transmission among at-risk populations. Effective cluster detection and response involves (1) strong partnerships among health departments, other service providers, and funding agencies; (2) strong connections with community partners and organizations that assist with response and intervention; and (3) high-quality, integrated data to support timely decision making. Flexible funding is critical for translating findings into response.

CDC recognizes the concerns of many marginalized communities about cluster detection and response. CAPT Oster stated that CDC gathers a range of perspectives and requires State and local health departments to engage affected communities, which is essential to minimize stigma and effectively deliver services. To address HIV criminalization, CDC and other Federal agencies provide guidance to States on reviewing and revising their laws to ensure confidentiality and data security. CDC and many Federal health agencies strictly protect HIV public health data and do not permit sharing of potentially identifiable data. CDC is not aware of any instances in which molecular data from surveillance has been used in court. It has released expanded guidance on the use of data that clarifies, for example, that local health departments should not use MHS data to determine directionality of transmission or share sequences with public repositories.

CAPT Oster shared some examples of how MHS was successfully used to identify and intervene in networks of transmission that otherwise would have been overlooked and to address gaps in programs and services. She emphasized that responses must be tailored to community needs and can incorporate various strategies, so no single outcome measure can assess the effectiveness of cluster detection and response. As CDC expands data collection, it has seen improvements across the HIV continuum from testing to viral suppression and improvements around related conditions, such as hepatitis, opioid use disorder, and endocarditis. Dr. Daskalakis referred participants to CDC’s new website of resources related to HIV cluster detection and response.

MHS from a Health Department Perspective

New York City

Sarah Braunstein, Ph.D., M.P.H., Assistant Commissioner, Bureau of Hepatitis, HIV, and STIs, New York City Department of Health and Mental Hygiene

Sarah Braunstein, Ph.D., M.P.H., said New York City (NYC) has been collecting MHS data since 2005, with support from the city’s legal infrastructure and State laws that protect individual confidentiality. Dr. Braunstein noted that while NYC has no HIV-specific criminalization statutes, PWH have been arrested and convicted under related laws, such as endangering a police officer.

Since 2007, NYC has used surveillance data to identify PWH not receiving HIV-related care and link them to services, which helps the city optimize its limited-service capacity. The city engaged early with the community to discuss the use of MHS and addressed legal and ethical
Effective MHS also relies on capturing the genotype of everyone tested, but many NYC providers are less likely to order genotyping for Black people, women, and people who use injection drugs compared with other patients. The city’s 2021 EHE plan includes efforts to improve equity by increasing the number of people who get baseline genotyping. Because cluster detection and response require a great deal of human resources, NYC’s 2021 EHE plan details the use of MHS to identify and prioritize services for PWH and people at high risk, including expanding surveillance to identify people with hepatitis C.

**Louisiana**

*Samuel Burgess, M.A., M.S.H.C.M., Director, STD/HIV/Hepatitis Program, Office of Public Health, Louisiana Department of Health*

Samuel Burgess, M.A., M.S.H.C.M., observed that the usefulness of MHS varies widely between states and localities because of differences in laws involving HIV, stigma, and inequities. As in New York City, genotyping is inconsistent in Louisiana. There is a significant lag between HIV diagnosis and availability of genotyping data for local health departments. It can take 2–3 months to recognize a cluster, which limits the utility of MHS for detection of rapid transmission. Since the Louisiana Office of Public Health (OPH) began passively monitoring MHS data in 2018, the State has identified nine clusters, affecting a total of 77 people. In these clusters, 77 percent of infected individuals were already in care and virally suppressed. In contrast, there were more than 1,400 new diagnoses in the State during the same period. Many of the clusters identified through MHS were in urban areas (e.g., New Orleans, Baton Rouge), and very few people in these clusters were from rural areas. Given the effort required to collect, analyze, and respond to MHS data, these results raise questions about its efficacy.

Through community engagement, particularly in developing EHE plans, OPH has educated stakeholders and advocates about MHS. Because Louisiana relaxed written and informed consent requirements to make HIV testing easier, concerns persist about the lack of consent by PWH for the use of genotype data for MHS. Although OPH can only use the data in limited ways, HIV infection and MPH data can be used for prosecution under the State’s HIV exposure statute, which does not recognize current science around transmission and does not require transmission for prosecution. Mr. Burgess said many people have been prosecuted under the State’s HIV exposure statute, particularly Latinx, Black, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) people.

Mr. Burgess stated that OPH is committed to ensuring that the community’s voice influences how it gathers and uses MHS data. Clearly, there is a continued need to promote timely linkage to care. Given the variations across jurisdictions in public health, Federal grant recipients need flexibility to focus on the interventions most appropriate for the local context.
Massachusetts

H. Dawn Fukuda, Sc.M., Director, Office of HIV/AIDS, Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Public Health

H. Dawn Fukuda, Sc.M., said the information gathered from MHS has proven so useful that Massachusetts prioritized investments in its capacity to receive and analyze HIV genotype data, and that extensive community engagement has been critical for this success. She appreciated the importance of balancing patient privacy with public health needs, but also noted that MHS complements other epidemiologic surveillance to inform and improve response to HIV outbreaks. Notably, Massachusetts has protective laws regarding disclosure of HIV and protections for PWH once they are diagnosed.

In two Massachusetts cities, MHS quickly identified an HIV outbreak associated with injection drugs and detected cases not revealed through interviews or other techniques. MHS enabled the Department of Public Health to accurately characterize the cluster and strengthened advocates’ arguments around the urgent need for syringe services programs. These syringe services programs, along with other services, were then rapidly approved and implemented. MHS also demonstrated how quickly HIV was transmitted, which helped increase understanding of contributing factors, such as behavior and environment, and the interventions that might be useful.

Ms. Fukuda added that MHS allowed the health department to identify connections between cluster cases, new diagnoses in other parts of the State, and existing diagnoses, which helped the department identify PWH who were out of care. The data also revealed clusters related to other States. She concluded that MHS has been very useful in Massachusetts but reiterated that the State’s political and legal context, in which individual information is highly protected, is crucial for successful use of MHS.

Discussion

During a brief discussion, Dr. Michael Saag asked about the cost of successful MHS programs. Mr. Burgess pointed out that in addition to the human resources involved in collecting and analyzing the data, implementing MHS involves a significant investment in community engagement. Ms. Fukuda added that extensive education and communication is vital. She stated that MHS should not be used if it does not lead to concrete interventions that benefit the community served.

Asked how to educate communities about MHS in a culturally appropriate way, panelists responded via chat. Mr. Burgess said the first step is for State health departments to take an official stand against archaic laws criminalizing HIV and work to eliminate or modernize them. This step is needed to demonstrate to the community that the health department prioritizes their concerns and seeks to create a safer, less stigmatizing environment.

Ms. Fukuda noted that Massachusetts conducted small-scale conversations with different groups and stakeholders and also relied on its own advisory group members to facilitate those discussions in various community venues and in multiple languages. The health department
provided informational materials (translated as needed) and presentations and made health department staff available to answer questions.

Dr. Braunstein echoed that education requires cautious, meaningful, ongoing engagement with affected communities, community partners, and other stakeholders about HIV surveillance and how MHS fits into core HIV public health efforts. Discussions should also address the legal and scientific contexts that underpin MHS. These conversations require health department staff to intently listen to and address community concerns so that MHS can implemented in partnership with affected communities.

MHS from a Community Perspective

Ronald S. Johnson, Senior Policy Fellow, AIDS United; Kamaria Laffrey, M.S., Program Director, SERO Project; and Robert Suttle, Chair, Council of Justice Leaders, The Elizabeth Taylor AIDS Foundation

Ronald S. Johnson, Kamaria Laffrey, M.S., and Robert Suttle, all members of the U.S. People Living with HIV Caucus emphasized that concerns about the potential negative impacts of MHS must be addressed before health departments increase and expand MHS programs. To date, MHS has been implemented rapidly and without involvement of PWH and others directly affected by HIV. Mr. Johnson said MHS is unacceptable without real recognition of the privacy and human rights concerns that it raises.

More than 30 States have laws criminalizing HIV, and current science is not part of the legal argument in favor of these laws. Communities most affected by HIV criminalization laws are also the most policed and face the most harm from law enforcement. Ms. Laffrey questioned whether the community engagement described by public health officials included marginalized groups such as sex workers, transgender and gender-nonconforming people, and people who use drugs. Ms. Laffrey noted that CDC has not provided tangible guidelines on data protections, particularly preventing data sharing with the Department of Homeland Security (DHS) and Immigration and Customs Enforcement (ICE). Although MHS itself cannot infer directionality of transmission, other data such as recency assay data can be combined with MHS as a proxy for directionality, which can be used by law enforcement to prosecute people.

Mr. Suttle pointed out that protections around individual data vary by State, as illustrated by NASTAD’s 2018 report, HIV Data Privacy and Confidentiality. This report concludes that health departments have broad authority to disclose personal data without the individual’s consent for a range of activities, including “justifiable public health need,” which need not be defined. States and jurisdictions vary on what can be shared, whether a subpoena or court order is required, and whether data can be used for research. Michigan, for example, has high rates of prosecution of PWH and allows all health records to be shared following a court order or subpoena. Mr. Suttle said Black men are likely overrepresented in Michigan’s cluster investigations.

Media coverage of HIV, particularly cluster detection, perpetuates stigma and foments hysteria that targets vulnerable communities, such as transgender women, who already face high rates of violence. Judges and juries are often influenced by implicit biases about PWH and other vulnerable communities, which often exacerbates the criminalization of HIV. Many PWH have been successfully prosecuted or had their reputations suffer without proof of HIV transmission.
Many legislators also perpetuate stigma around HIV when clusters are identified, which can lead to laws that further criminalize HIV. Mr. Johnson said numerous reports published over the past several years have raised concerns around implementation of MHS. He also highlighted some efforts to push back against MHS in the general media and scientific literature.

The speakers outlined several recommendations that PACHA could make to address the use of MHS:

- Enhance meaningful involvement of PWH in the domestic HIV response
- Develop Federal guidance on data collection and use, informed consent, and community engagement
- Create national standards for HIV data protection
- Require funded EHE jurisdictions to work toward creating an affirming human rights environment for PWH

Mr. Suttle and Ms. Laffrey emphasized the importance of accountability among organizations that purport to serve PWH and promote public health. The speakers, along with other representatives of the Caucus and networks of PWH, seek involvement in PACHA’s future deliberations around MHS.

Discussion

Ms. Laffrey noted that the public health officials promoted MHS as a way to get data to provide services, but she wondered why resources could not be directed to prioritize the needs of all PWH, not just those identified by cluster detection. Mr. Suttle added that although MHS appears to offer promise, without privacy protection and in the face of HIV criminalization, MHS is a tool to stigmatize and burden PWH. Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., observed that MHS cannot rely on science alone to fulfill its potential; structural racism must be addressed across the board.

Ms. McNeese said that, in her experience as a public health official in Houston, no time was allotted for community engagement before MHS was implemented. Dr. Daskalakis stated that public health leaders are striving to work with advocates, PWH, and others to implement MHS in a respectful, effective way, adding that all stakeholders have the same goal of ending HIV. Mr. Smith noted that partnering with the media can be one mechanism for addressing stigma.

Closing Remarks and Recess

Ms. McNeese appreciated the work and energy that went into creating an agenda filled with thoughtful presentations. Dr. Wiesman acknowledged that the fears around HIV criminalization are real and understandable, and he entreated PACHA to challenge and modernize outdated laws that are not scientifically based and hamper HIV prevention and care. PACHA members can make recommendations and leverage their professional networks but modernizing these laws will require effort from many more stakeholders. Dr. Wiesman recessed the meeting for the day at 4:56 p.m.
Day 2

Opening Remarks from the PACHA Co-Chair
Dr. Wiesman welcomed the participants at 1:00 p.m. He reviewed the proceedings of Day 1 and the agenda for Day 2.

Roll Call
Ms. Hayes called the roll.

Reflections from the CHAC Meeting
Wendy Armstrong, M.D., FIDSA, CHAC Liaison
At its November meeting, CHAC discussed several issues relevant to PACHA:

- Proposals to increase flexibility of the Ryan White program to decrease barriers to care
- Use of telemedicine during the COVID-19 pandemic to ensure care for PWH, including creating a working group to further explore telemedicine for PWH
- Challenges facing STI screening among PWH in Ryan White programs, including insufficient insurance coverage and high-cost medications
- Improving communication and coordination among health departments and agencies that provide housing, substance use disorder, mental health, and HIV services
- Updated guidelines for hepatitis B screening
- Assessment of HIV care outcomes beyond viral load, such as quality of life and well-being

Discussion
Dr. Armstrong noted that the discussion around STI screening among PWH raised specific topics that PACHA could help address, such as high drug costs, insurance coverage that reflects evidence-based recommendations for screening intervals, and acceptance of home testing. Dr. Wiesman pointed out that the Infrastructure Investment and Jobs Act passed recently will expand broadband internet service, which should increase access to telemedicine.

Private-Sector Engagement: Innovative and Strategic Partnerships
Mr. Schmid and Tori Cooper, M.P.H., explained that the White House asked PACHA for guidance on involving the private sector in achieving the goals of the updated NHAS and the EHE initiative. In response, the EHE and HIV Strategy Subcommittee held sessions with invited speakers and drafted a letter for the Secretary with suggestions, to be discussed by the Council later.

Ms. Cooper acknowledged that November 13–19 was Transgender Awareness Week, and November 20 is the annual Transgender Day of Remembrance. Transgender people are still disproportionately affected by HIV and inequities in HIV care systems.
Private-Sector Engagement with the EHE Initiative

Sara Ziegler, M.P.A., Associate Director for Policy, NCHHSTP, CDC

Sara Ziegler, M.P.A., clarified that “private sector” refers to organizations that are not overseen by the Federal government and that can act without soliciting government resources. She outlined some opportunities for private-sector involvement, such as the following:

- Health care businesses (e.g., health insurance, hospital systems, provider associations, pharmacy groups) can support routine HIV testing and syringe services programs.
- Philanthropic organizations can fund educational campaigns or address EHE and NHAS goals as part of high-profile events with public figures.
- Businesses can support wraparound services, such as transportation and childcare.
- Private partners can offer in-kind support that expands research capacity and program implementation.

Employers can ensure their boards include people with lived experience relevant to HIV. They can incorporate HIV testing and prevention in their wellness campaigns and ensure that their insurance plans cover HIV prevention, testing, and care. Employers can also ensure that LGBTQ employees are supported and safe in the workplace.

Private-sector engagement can be encouraged through incentives and recognition. National programs, such as HHS’ Million Hearts Hypertension Control Challenge, allow private organizations a platform to showcase best practices and garner positive attention. Efforts to involve the private sector must promote access to easy-to-adopt toolkits and step-by-step practices for implementation. Engagement offers opportunities to leverage existing coalitions and formalize new ones.

Working with the Business Community

Stephen Massey, M.I.A., Co-Founder, Meteorite

Stephen Massey, M.I.A., stated that Americans trust businesses, particularly their own employers, and expect businesses to take on social challenges. He described his organization’s work with the Civic Alliance, a coalition of more than 1,000 companies seeking to support voter participation and safe, secure elections in the United States. As a result of the Civic Alliance’s efforts, many companies have taken steps to encourage voting (e.g., time off for voting and paid time off for volunteering at voting centers). In 2020, members of the Civic Alliance helped inspire record-high election participation. Civic Alliance members recruited more than 700,000 new poll workers, donated supplies, and signed statements supporting free and secure elections.

Many businesses are willing to address large social issues, but creating effective alliances takes time to build trust and credibility. Businesses prefer to participate in empowering and positive frameworks with action steps for achieving progress. They recognize that engaging in social issues can be good for business.

Another example of successful private-sector engagement is the Health Action Alliance to combat COVID-19. It brought together more than 1,500 businesses and provided tools and events that fostered partnerships between the private sector and public health agencies. Since the
Health Action Alliance was formed in February 2021, participating employers have had a strong impact on vaccine uptake by encouraging or requiring vaccination, and in some cases, providing paid time off for vaccination appointments and recovery. The alliance’s approach was recognized as a blueprint for companies that want to boost COVID-19 vaccination rates. Mr. Massey highlighted four key insights from the Health Action Alliance:

- Positioning matters. Communicate that there are public health solutions to critical business challenges.
- Provide clear, evidence-based actions that businesses can take. Offer tools and training, as well as best practices from within the private sector.
- Move at the speed of business. Create a coalition that can respond in real time to emerging needs and opportunities.
- Provide current public health data and trusted sources of information and guidance.

Mr. Massey added that an alliance should demonstrate how the partnership will benefit workplaces and communities. He recommended identifying champions among corporate leaders and developing a coalition that can weather shifting political winds. Efforts should clarify specific actions that businesses can take and offer tools for diverse types of businesses, particularly small and medium-sized businesses. Mr. Massey concluded that private industry partnerships offer an opportunity to significantly impact public health efforts.

Mobilizing Media

DaShawn Usher, Founder and Executive Director, Mobilizing Our Brothers Initiative (MOBI), and Associate Director, Communities of Color, GLAAD

Mr. Usher summarized how MOBI and GLAAD worked with media at all levels to amplify the stories of PWH. MOBI was created in 2017 to offer a more holistic portrayal of Black gay men in the media through an arts and wellness festival (MOBIFest) and discussion series (MOBITalks). In 2021, MOBI joined with Forbes magazine on a week-long cultural event, For(bes) the Culture, highlighting Black queer entrepreneurs, among others. The magazine ran a feature article about the event. Mr. Usher said MOBI has worked intentionally to engage media and spark conversations with and about Black gay men outside the usual bubbles.

MOBI partnered with business to provide a holistic view of wellness, fashion, and expression as part of the experience of Black gay men. With Nylon magazine, MOBI organized the Take Pride campaign to feature queer people of color in Pride awareness initiatives and in outlets not traditionally associated with Pride month coverage. Mr. Usher presented a video news feature spotlighting a gay Black fashion designer, noting that it offers an example of leveraging the power of influencers and their platforms.

GLAAD received funding from a pharmaceutical company to provide media training and amplify Black queer voices in the media and entertainment industries. The program, Accelerate Compassion in Action, has sponsored events bringing together leaders in media, entertainment, and faith communities. GLAAD quickly responded to homophobic statements made by rapper DaBaby and amplified Lil Nas X’s message during the MTV Video Music Awards about uplifting PWH in the South. GLAAD also issued a call to action asking Hollywood to engage more PWH in all aspects of storytelling.
**Discussion**

Mr. Schmid asked for specific steps to engage the private sector. Mr. Usher responded that affected communities must be included throughout private-sector engagement, and Ms. Ziegler echoed the importance of centering private partnerships around community needs. She added that any declarations or agreements should clearly state who is leading the effort, the intended goals, and how all the partners will be held accountable for achieving the goals.

Mr. Massey said the PACHA Subcommittee’s draft letter to the Secretary offers a powerful vision, and the next step is engaging private-sector leaders and articulating reasons for business participation. One way to center business efforts around community needs is to focus on the needs of employees with HIV or at high risk for HIV. In addition, an infrastructure must be in place to mobilize businesses and provide resources quickly. Ms. Cooper added that companies are finally beginning to recognize the consumer power of PWH. Leo Moore, M.D., M.S.H.P.M., pointed out that few life insurance companies offer policies for PWH, so encouraging companies to provide access to life insurance to people on PrEP is an important step that businesses could take toward ending HIV.

To support PWH who lack health care and resources, Mr. Massey proposed collaborating with small and medium-sized businesses, which play a significant role in many communities. However, tools and guidance for building private-sector coalitions often overlook the role of small businesses. Mr. Massey recommended working with local chambers of commerce, local health departments, and other civic organizations in affected communities to develop targeted interventions.

To raise awareness about issues affecting PWH, many marketing and outreach campaigns need more resources to amplify and sustain these campaigns. Mr. Moore said outreach efforts should consider how to partner with small media companies to make an impact. Raniyah Copeland, M.P.H., added that effective public–private partnerships should bring in businesses that can engage with the community affected and help build trust.

Ms. Ziegler noted that incentives for business participation vary, illustrating the challenge of managing a broad coalition of partners. She recommended undertaking some small demonstration projects and disseminating the successful results to show the mutual benefits of partnership. She reiterated the need for specific steps for HIV prevention and care. Mr. Usher stated the importance of bringing HIV prevention and care into other conversations, such as the recent focus on diversity, equity, and inclusion in the private and public sectors. Making an effective business case means highlighting how public health solutions can solve corporate challenges, such as improving worker health and safety and reducing health care costs.

Guillermo Chacón emphasized that community involvement in public–private partnerships require clear rules of engagement that specify community roles and emphasize addressing HIV in the broader context of health care, wellness, and quality of life at the individual, city, state, and Federal level.
Although formal efforts to work with the private sector around HIV date back to the 1990s, the Federal government is taking a new approach. Although addressing HIV is ultimately in the country’s interest, engaging businesses can pose challenges because the effects of HIV are not as immediately evident as the COVID-19 pandemic or other health issues. To address these challenges, Dr. Kates proposed market segmentation and targeting efforts, particularly in workplaces or communities highly affected by HIV. Mr. Massey emphasized that the Federal government has put forth a powerful new vision about ending HIV, and businesses can help. The pandemic has raised businesses’ awareness about their role in public health, so there is an opportunity to act.

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, suggested creating a framework that outlines the kinds of activities that enhance the benefits and mitigate the negative consequences of private-sector involvement. He also hoped efforts would move beyond addressing conditions in the workplace that affect health and instead offer a broader, systemic vision of conditions that perpetuate inequality.

Mr. Usher said that centering community is one way to chip away at stigma, which makes it especially important to include marginalized communities. Ms. Cooper pointed out that the nature and language of HIV advocacy has changed, and businesses should acknowledge that ending HIV is intertwined with LGBTQ—particularly transgender—rights.

### Getting Ahead of the Ball: How COVID-19 Has Impacted Our HIV Work and Planning for 2022 and Beyond

**Tennessee**

*Meredith Brantley, Ph.D., M.P.H., HIV Program Director, HIV/STI/Viral Hepatitis, Tennessee Department of Health*

Meredith Brantley, Ph.D., M.P.H., noted that, as the COVID-19 pandemic hit in early 2020, HIV clinical staff supported COVID-19 activities while still sustaining their HIV work with minimal disruptions. In Tennessee, funding for HIV testing dropped dramatically in 2020, and the number of new enrollees in Ryan White programs was only slightly higher than 2019. The State funded more new syringe service programs in 2020 and 2021; it also experienced a significant increase in nonfatal opioid overdoses in the first few months of the pandemic compared with the same period in 2019.

Despite these challenges, Tennessee’s public health departments maintained HIV services with some success. By April 2020, they began offering home HIV testing kits through partner organizations, demonstrating the feasibility and acceptability of home testing, which will inform State-wide adoption. The pandemic also led to virtual training for partner agencies. In 2021, the health department provided 50 virtual training sessions reaching 900 participants—three times the typical number—and engaged new partners. The State’s “End the Syndemic” initiative launched in March 2020 and quickly pivoted to a virtual format for its intensive community engagement approach. The effort has already produced some guidance and illustrated the value of breaking down siloes.

Dr. Brantley outlined some critical steps for the future:
• Acknowledge the trauma and burnout that workers face during a public health crisis and think about how compensation and the environment can be adapted to retain staff.
• Recognize the invaluable perspectives that people on the front lines and people with lived experience contribute to the team.
• Facilitate access by offering as many options as possible for engagement and continue to seek creative solutions.
• Collaborate and integrate across HIV, STI, hepatitis, and substance use disorder programs, taking a holistic approach to achieving long-term goals.

Texas
Wally Cantú, CEO, Valley AIDS Council (VAC) and Westbrook Clinics

The pandemic exacerbated existing inequities in access to care and insurance coverage as well as shortcomings in public health systems. At the Texas border with Mexico, where the VAC clinics operate, those inequities include high rates of uninsured people, limited access to Medicaid, and insufficient water, sewer, and electric systems.

When the pandemic started, VAC canceled social events previously used to serve many communities and postponed the opening of its new youth resource center. The State’s political leaders offered mixed messages on sheltering in place and getting the COVID-19 vaccine, creating setbacks that were compounded by a power grid failure following a snowstorm. VAC implemented telehealth options, provided drive-up services, and mailed prescriptions and food vouchers to some clients. Some of these efforts relied on savings realized through the 340B drug pricing program and COVID-19 relief dollars. The number of PWH receiving care from VAC has been increasing since 2019, with a significant uptick of new clients between 2020 and 2021.

Wally Cantú noted some successes, such as the quick pivot to virtual care and support, willingness to pursue novel approaches to outreach and testing, and increased collaboration with other public health agencies to provide COVID-19 education, outreach, and vaccines. Mr. Cantú said many of VAC’s initiatives were inspired by the National Hispanic/Latinx Health Policy Agenda, 2020–2024, published in September 2020.

IHS
Rick Haverkate, M.P.H., National HIV/AIDS & Hepatitis C Program Coordinator, IHS

Rick Haverkate, M.P.H., explained that IHS surveyed clinicians in its facilities in May, August, and December 2020 about the impact of COVID-19 on HIV care. Overall, it appeared that COVID-19 had a moderate to minimal effect on HIV care. By August, HIV programs had begun mailing prescriptions and had models to identify patients requiring in-person services. However, many survey respondents said the overall quality of care declined and that effects of COVID-19 would manifest over time.

As COVID-19 required more resources, many sites shut down, erasing progress in integrating HIV care and other services. By May 2020, many programs were operating entirely virtually, with services limited to those that could be provided via telemedicine. One site reported an increase in services provided, which might have been the result of people returning to their
homes on a reservation, possibly because of economic pressure. Another site reported that treatment adherence improved. COVID-19 emergency housing protocols helped provide stability for some PWH. IHS sites continue to report that laboratory resources are in high demand for processing COVID-19 tests and lack bandwidth to address PrEP tests, so IHS is working with the field to address the issue.

Mr. Haverkate said the strength of IHS lies in its connection with providers through the Indian Country Extension for Community Health Outcomes (ECHO) program, which provided updated information on emergency care, COVID-19, PrEP, transgender affirming care, substance use disorders, and more.

**NASTAD**

*Emily McCloskey, Director, Policy & Legislative Affairs, NASTAD*

NASTAD requested information from members on the impact of COVID-19 on Ryan White programs, HIV prevention programs, hepatitis programs, and EHE initiatives. The pandemic had a profound impact on the economy, and although there has been some economic recovery, many States are still dealing with an influx of uninsured patients and increased enrollment in Ryan White programs. Emergency relief addressed some shortfalls, but State and local health departments are still working with lower budgets.

About 70 percent of Ryan White programs reported that staff reassignments to COVID-19 response have negatively impacted Ryan White programs and that the economic downturn will have a long-term impact on the AIDS Drug Assistance Program (ADAP). Most programs used Federal relief funding to increase provider capacity and help clients pay for housing, food, and utilities.

HIV prevention programs reported persistent challenges for outreach and prevention services. Many programs have shifted to home HIV testing and are seeking innovative approaches to outreach. Hepatitis programs historically have been understaffed and underfunded, so the loss of staff to COVID-19 programs was profound. State staff furloughs and hiring freezes will likely have a negative impact on public health infrastructure and hepatitis response. Nearly 80 percent of EHE jurisdiction respondents said that they need more time to reach PWH and those at risk for HIV and to ensure community engagement. As previous speakers noted, health departments ramped up home testing and telemedicine during the pandemic. Emily McCloskey summed up some key lessons learned:

- Telehealth and telemedicine have proven effective, so the Federal government and State health departments should continue to allow flexibility to expand and promote such services.
- Virtual training represents a great advance for educational opportunities.
- The pandemic response highlighted how a publicly funded infectious disease testing system works.
- The pandemic revealed the need to provide behavioral services through a system that addresses the whole person.
Florida

Emily Rokosch, M.Ed., Director of Operations, JASMYN

Emily Rokosch, M.Ed., described JASMYN, a center for queer youth and young adults in Jacksonville, FL, as an open, inviting space for people to gather and get services without an appointment in a relaxed, non-clinical atmosphere. The pandemic forced JASMYN to limit its hours and facility usage, require appointments, implement restrictive safety protocols, and respond more slowly because fewer staff members were available. HIV testing was paused for a few months; when it restarted, the number of positive tests was very high.

COVID-19 made it challenging to coordinate services, build relationships with clients, and provide a safe workspace that is also welcoming and comfortable. The pandemic magnified existing barriers, such as lack of housing, transportation, and mental health services. To overcome some of these barriers, staff members provided HIV tests in public parks and on the streets, and they delivered food and condoms in public spaces.

JASMYN now recognizes the importance of cross-training staff so that it has the flexibility to provide and maintain services. The pandemic broke down some structural barriers, such as requirements related to ADAP eligibility, which allowed JASMYN to improve links to care and PrEP services. The organization is working to rebuild connections and bring young people back into the facility. It will have longer hours so that it can provide services while limiting the number of people on site at any given time. Ms. Rokosch said that restarting the program is an opportunity to improve the program based on lessons learned.

Discussion

Laura Cheever, M.D., Sc.M., said the Ryan White HIV/AIDS Program Services Report for 2020 will be released December 1, 2021, and it will provide comparisons with 2019 data to assess the impact of COVID-19 on Ryan White programs.

Ms. McNeese invited the speakers to spotlight one issue that could accelerate the response to HIV. Ms. Rokosch cautioned that telemedicine is not safe or accessible for everyone, so removing structural barriers to access is crucial. Ms. McCloskey expressed enthusiasm for guidance from HRSA that would enable some providers to continue offering telemedicine, but she echoed the need to meet people where they are by providing options for in-person care.

Dr. Brantley stressed the importance of modernizing the public health workforce, including hiring people with lived experience, creating positions focused on implementing culturally competent services, and paying staff more money so that their compensation aligns with their value. Upgrading the workforce will require tailored leadership and training programs and requirements for funding that can be assessed and evaluated using defined standards and metrics.

Mr. Haverkate said Indian Country has always been good at adapting to new conditions. IHS facilities could take advantage of changing technology. IHS is also developing a dynamic approach to case management that relies on community health workers, expands protocols and training, capitalizes on the Indian Country ECHO program to disseminate data, and promotes training and care in rural communities.
Mr. Cantú said VAC was able to provide services thanks to its 340B funds. Such funds should continue to be available and should be accessible for serving PWH and those at risk for HIV.

**Public Comments**

Ace Robinson of the Federal AIDS Partnership appreciated the acknowledgment of Transgender Awareness Week and the Transgender Day of Remembrance. However, he noted that such events would not be needed if the cisgender community had never taken the efforts and lives of transgender and gender non-conforming people for granted. Taking others for granted still happens too often, and the community must do better, said Mr. Robinson.

Mr. Robinson said too little attention is given to harm reduction. The United States just surpassed 100,000 overdose deaths in 2021. New records are set every year, bringing a new level of preventable pain for the families of people with substance use disorders. As such, there is a growing need for culturally responsive and timely harm reduction services. Mr. Robinson called for increased collaboration across SAMHSA, Housing Opportunities for Persons with AIDS, and CDC to provide dedicated services. When such programs are fully staffed, the country can stop spinning its wheels. Each day of delay, more lives are lost, Mr. Robinson concluded.

Amir Sadeghi of the Center for HIV Law and Policy (CHLP) supported the power of advocacy movements to dismantle public health strategies that dehumanize PWH and undermine their autonomy and fundamental rights. He noted the growing consensus around the risks associated with the implementation of MHS. CHLP questions whether the level of investment MHS is the best use of extremely scarce resources in many HIV hotspots across the United States where people are dying because of racist and structural barriers to care. Networks of PWH, including the Positive Justice Project, have raised the alarm on the many gaps in the patchwork of policies protecting health data since the mandatory MHS program was announced in 2017. For decades, CHLP has asked that CDC support its pronouncements by declaring a national policy that places identifiable data behind a firewall, safe from law enforcement access, and requires grantees to do the same. People are fearful about public health surveillance data being weaponized against them, particularly in communities where public health systems are working hardest to engage their communities, said Mr. Sadeghi. These are the same communities most likely to be targeted by HIV criminalization in the majority of States. Mr. Sadeghi also noted that personal consent to the collection and sharing of health information is a basic part of human dignity.

Mr. Sadeghi stated that CDC has acknowledged at every step that law enforcement should not access sensitive data while simultaneously refusing to enshrine this principle in policy. Ending the HIV epidemic is only possible if people have trust in our health and public health systems. Mr. Sadeghi said that ending the HIV epidemic is only possible if people have trust in their health and public health systems, and this administration and Federal agencies have one path toward that outcome: clear and concrete protections that end the use of public health and personal health data as a vehicle to punish PWH.

Breanna Diaz, policy director of the Positive Women’s Network, said her organization and several others continue to call for a moratorium on MHS until community concerns are met. She expressed concern about the problematic reframing of MHS, noting that health departments can
already identify gaps in services for PWH without MHS. She proposed that public health agencies upgrade supportive services for all PWH, not just those identified by cluster detection. Ms. Diaz disagreed with the statement that communities, particularly PWH, have been engaged in discussions about MHS; neither the Positive Women’s Network nor other advocacy groups were aware of plans to incorporate MHS into EHE. Ms. Diaz urged CDC to engage directly with communities that are disproportionately policed, including PWH, people of color, sex workers, immigrants, and LGBTQ people. She further called on PACHA to partner with PWH and to invite advocates into further discussions around MHS as it considers its recommendations.

**Heather O’Connor of the International Community of Women Living with HIV—North America**, supported the meaningful involvement of PWH, particularly women with HIV who breastfeed their infants, in policymaking. Currently, CDC does not recommend that women with HIV breastfeed, which conflicts with other guidelines and causes confusion for women. Studies indicate that the risk of vertical transmission through breastfeeding is less than 1 percent when the mother has achieved viral suppression. CDC is planning to update its guidelines, so Ms. O’Connor called for PWH to provide input into this process. Ms. O’Connor shared that she has HIV and breastfed her children, with the support of her health care providers. People with relevant lived experience should be at the table for decisions about policies. Because of CDC guidelines, many women have been criminalized or denied breastfeeding support resources. This issue must be addressed to protect the safety of women with HIV, she concluded.

**Devin Hursey of the Black Treatment Advocates Network** called for increased transparency, accountability, and representation from organizations funded by the Federal government, specifically the Black AIDS Institute, which has received $8 million from HRSA. The Black Treatment Advocates Network has formally requested documentation from the Black AIDS Institute about its recent work and has received no response. The Network calls for the board of the Black AIDS Institute to hold elections and welcome members who represent the landscape of Black PWH; commit to unbiased, transparent leadership; and remove board members who have exceeded their term limits. Mr. Hursey said the Network’s requests are a matter of racial justice, as Black people, particularly Black PWH, should be represented at the highest levels of leadership. He thanked Ms. Copeland for her work during her tenure at the Black AIDS Institute.

**Gina Brown**, former PACHA member, said it is important for PACHA to think about how to foster leadership among Black women. Few women are engaged in HIV advocacy, especially at the highest levels of leadership. The Ryan White program requires that grantees have HIV health services planning councils and that at least one third of members of such councils be people who receive Ryan White program services. Ms. Brown proposed that PACHA advocate for similar mandates for all organizations that receive Federal funding to serve PWH. She also commemorated the Transgender Day of Remembrance.

See Appendix A for all written public comments submitted.
PACHA Letter to the HHS Secretary on Private-Sector Engagement in the EHE Initiative

Mr. Schmid noted that the frequent call for a whole-of-society approach to the EHE initiative requires private-sector involvement. The EHE and HIV Strategy Subcommittee drafted a letter to Secretary Becerra explaining how businesses, including media companies, can contribute to eliminating stigma around HIV. The letter offers multiple suggestions, such as the creation of a task force that can serve as a central organizing body for private-sector engagement and provision of staff resources to support such engagement. Mr. Schmid summarized the key points of the draft letter, which had been circulated to PACHA members in advance for review.

Based on discussions at this meeting, Mr. Schmid proposed adding to the letter a clear statement that PWH and other affected community representatives should be part of the central organizing body alongside diverse private-sector partners. PACHA members agreed. Another member noted that the organizing body’s efforts should be evaluated periodically to assess its progress, and PACHA members agreed that a statement about evaluation should be added.

Vote
The Council voted unanimously in favor of finalizing the letter, as amended.

See Appendix B for the final letter.

Open Discussion Among PACHA Members

MHS
Rafaelé Narváez observed that PACHA should pay close attention to the skepticism expressed about MHS. Despite claims from Federal agencies, Mr. Narváez believed that many communities were not consulted about the use of MHS before it was implemented. Dr. Wheeler said that the use of MHS exemplifies the persistent problem of structural barriers that exclude affected groups from participation. Marc Meachem pointed out that advocates should not wait for public health agencies to contact them but rather should speak up when they see issues of concern on the docket.

Future Agenda Items
- Revisit the issues around the HIV workforce, given that many seasoned providers are retiring and that implementing EHE could increase the number of PWH in care by 400,000. Consider establishing a new PACHA subcommittee on the HIV workforce. The subcommittee’s agenda should include
  - pathways to leadership;
  - organizational development to support the creation and advancement of a well-equipped workforce; and
  - opportunities for people to work without losing Supplemental Security Income or Social Security Disability Insurance benefits.
- Consider presentations from a selection of Ryan White program board members across the country on the state of HIV in their communities.
- Continue to address PrEP access in light of changes to programs and consider potential recommendations to promote access.

Dr. Daskalakis praised PACHA for fostering good conversations that bring forward different viewpoints. He was encouraged by the fact that, despite some differences, all of the presenters, PACHA members, and public commenters are working toward the same goal of ending HIV.

**Next Steps and Closing Remarks from the PACHA Co-Chairs**

Dr. Wiesman reminded participants that nominations for new PACHA members are open until January 3, 2022, and he appreciated the Biden administration’s efforts to expand the Council membership to make it more inclusive. He pointed out that Ms. Cooper’s commemoration of Transgender Awareness Week and the Transgender Day of Remembrance is an example of the importance of having a diverse and inclusive Council.

As an immediate next step, PACHA’s Stigma Subcommittee will convene with stakeholders in early 2022 around MHS and work toward recommendations for the full Council’s consideration. The PACHA Co-Chairs and subcommittee co-chairs will discuss forming a new subcommittee on the HIV workforce.

Dr. Wiesman appreciated the outstanding work of Kaye Hayes, M.P.A., Caroline Talev, M.P.A., and the entire PACHA team for organizing the meeting. He also thanked the PACHA members who planned the panel discussions as well as all those who contributed. He wished the participants a happy holiday season and adjourned the meeting at 4:55 p.m.
# Appendix A: Written Public Comments

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## Presidential Advisory Council on HIV/AIDS

**72nd Full Council Virtual Meeting**  
**Pre-Registration and Public Comment List**  
**November 15 and November 17, 2021**

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<tr>
<td>1</td>
<td>Robinson, Ace</td>
<td>Co-Chair, Federal AIDS Partnership</td>
<td>Chief Mission Officer, Covid Clinic</td>
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<td>Vance, Alex</td>
<td>Senior Director, Advocacy &amp; Public Policy</td>
<td>International Association of Providers of AIDS Care</td>
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<td>Hopkins, Ernest</td>
<td>Senior Strategist and Advisor</td>
<td>San Francisco AIDS Foundation</td>
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<td>Sadeghi, Amri</td>
<td>National Policy and Partner Strategist</td>
<td>The Center for HIV Law and Policy</td>
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<td>Diaz, Breanna</td>
<td>Policy Director</td>
<td>Positive Women's Network-USA</td>
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<td>Johnson, Devon</td>
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<td>8</td>
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<td>9</td>
<td>Danielle Campbell</td>
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<td>McColl, Bill</td>
<td>Senior Consultant</td>
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The Center for HIV Law & Policy works to address stigma and discrimination at the intersection of HIV, race, disability, class, sexuality, and gender identity, with a focus on criminal and public health systems. We’ve supported the advocacy power of movements dismantling harmful approaches to public health issues, including public health strategies that confront and dehumanize people living with HIV, that undermine their bodily autonomy and fundamental rights. We are part of a growing consensus of people living with HIV, public health professionals, and legal experts who stress the risks associated with the implementation of molecular HIV surveillance. We question whether the level of investment in this form of research is the best use of extremely scarce resources in the many under-addressed HIV hotspots across the US where people are dying because of racist and structural barriers to care. Networks of people living with HIV, including the Positive Justice Project, have raised the alarm on the many gaps in the patchwork of policies protecting health data since the mandatory molecular HIV surveillance program was announced in 2017. For decades, CHLP and staff have asked that CDC put its policies where its pronouncements are by declaring a national policy to firewall identifiable data from law enforcement access, and to condition its funding on a grantee's commitment to do the same. People are fearful about public health surveillance data being weaponized against them - against the communities who our public health systems are working hardest to engage. Those fears are deepened by the fact that these are the same communities most likely to be targeted by HIV criminal legal enforcement in what is still a majority of US states that prosecute alleged HIV nondisclosure and exposure. But beyond this, it is a basic part of human dignity to have a say in how one's personal health information is used. Despite CDC being asked multiple times, in a variety of formats, to require barriers separating health data collection from law enforcement and immigration enforcement, these requests have gone unanswered. CDC has acknowledged at every step that law enforcement should not access this data while simultaneously refusing to enshrine this
principle in policy. Protecting identifiable health data means protecting communities, which is fundamental to building trust in our public health data infrastructure. If CDC is serious on the need to protect public health surveillance information from being accessed by law enforcement they can and should incorporate requirements for such protection in all CDC grant programs.

Mechanisms to counter medical mistrust through clear policies on data privacy should be considered and implemented before, not after, an initiative such as MHS is rolled out. Ending the HIV epidemic is only possible if people have trust in our health and public health systems. This administration and federal agencies have one path towards that outcome: clear, concrete protections that end the use of public health and personal health data as a vehicle to punish people living with HIV.

Written Testimony #1:

From: Jean Public <jeanpublic1@yahoo.com>
Sent: Sunday, October 3, 2021 3:56 PM
To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>; info@taxpayer.net; media@cagw.org; info@afphq.org; info@retiredpatriots.org
Subject: Fw: cut funding to this activity – public comment on federal register

I am in favor of cutting all American tax dollars to this activity. This frightening disease has come up with ways of treating it so that no further action is needed. To fund this advisory council and all the other grants in the billions of dollars is wasted American tax dollars when the entire nation is suffering from a pandemic and the nation needs the tax dollars for the pandemic. This is selfish greed for a small group of people when the entire nation is suffering. This comment is for the public record. Please receipt. Jean Public jeanpublic1@gmail.com, this is another example where propaganda and fakery does away with truth.

[Federal Register Volume 86, Number 187 (Thursday, September 30, 2021)]
[Notices]
[Pages 54223-54224]
From the Federal Register Online via the Government Publishing Office [www.gpo.gov]
[FR Doc No: 2021-21275]

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 72nd full Council meeting utilizing virtual technology on Monday, November, 15 and Wednesday, November, 17, 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, November 8, 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, November 24,
DATES: The meeting will be held on Monday, November, 15 and Wednesday, November, 17, 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.

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. 2021-21275 Filed 9-29-21; 8:45 am]
BILLING CODE 4150-43-P
Appendix B: PACHA Letter to the HHS Secretary

November 17, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Involvement of Private Sector in the Ending the HIV Epidemic in the United States

Dear Secretary Becerra:

We are pleased that you and the Biden administration are proceeding with efforts to end the HIV epidemic in the United States by 2030 and are devoting the necessary resources and changing policies to help meet this goal. To date, many of the activities to increase HIV prevention and treatment have centered on government-funded programs and partnering with impacted communities. To better ensure that ending the HIV epidemic is a whole-of-society effort, we urge you to facilitate the inclusion of the private sector as part of the initiative to harness their expertise and resources in helping meet the goals of ending the HIV epidemic by 2030.

We believe that the private sector can play a significant role in helping reduce new HIV transmissions and increase viral suppression. Those involved in our nation’s effort to end the HIV epidemic should include those private sector entities that work directly in HIV prevention and treatment, are involved in healthcare delivery, have major employee or purchaser bases impacted by HIV, or can influence society. Harnessing their participation at both the national and local levels can help leverage the work that is already being done by governments and the HIV community across the nation while at the same time addressing the stigma that is often associated with HIV. While there are entities in the private sector that are already contributing to this effort, we believe many more would welcome the opportunity to participate if they were just asked.

Therefore, the Presidential Advisory Council on HIV/AIDS (PACHA) urges you to work with agencies in your department and others in the Biden Administration, including the White House, to facilitate the establishment of a private sector component in the nationwide effort to end HIV in the United States.
As part of this effort, we recommend that it include the following components:

1) An entity be established composed of diverse private sector partners that includes people living with HIV/AIDS and other affected community representatives to serve as a central organizing body to prioritize activities and share best practices.

2) Dedicate staff resources to the program and organizing body.

3) The White House and HHS should conduct periodic events to show how private sector involvement can improve the HIV response, particularly in the communities most impacted.

4) Private sector involvement should come from both traditional and non-traditional partners, including those directly involved with HIV prevention and treatment, healthcare delivery, have major employee or purchaser bases impacted by HIV, or have the ability to impact and influence parts or all of society.

5) In addition to private companies, others involved should be foundations and other non-profits, unions, religious groups, entertainers, cultural and educational institutions.

6) Private sector involvement should speak to the communities most impacted and disproportionately impacted by HIV, including gay men, particularly those who are Black or Latino, Black women, transgender women, young people, American Indians/Alaska Natives, people who misuse substances, and people living in the South.

7) The private sector should help address the social determinants of health that impact HIV, including racism, homophobia, housing, poverty, education, and employment and training.

8) Efforts should be developed for both the national and local community levels.

9) Tool kits for activities should be developed, along with opportunities for recognition and measuring results.

10) The organizing body should work with HHS, the HIV community, and other HIV experts to determine the goals that can most directly accelerate the HIV response in the US and evaluate the achievement of those goals.

This letter was unanimously adopted by PACHA at its meeting, conducted virtually, on November 17, 2021. We look forward to your response and working with you and your Department on implementing our recommendations. Thank you very much.

Sincerely,

Marlene McNeese
Co-Chair

John Wiesman
Co-Chair

cc: Admiral Rachel L. Levine, MD, Assistant Secretary for Health, US Department of Health and Human Services (HHS)
B. Kaye Hayes, MPH, Acting Director, Office of Infectious Disease and HIV/AIDS
Policy (OIDP) and Executive Director of PACHA, OASH, HHS
Harold Phillips, MRP, Director, White House Office of National AIDS Policy