ANEA/AIDS United Public Comment on the HIV National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic 2021-2025

After having had time to look over the recent draft release of the Department of Health and Human Service’s “HIV National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic 2021-2025”, the Act Now End AIDS Coalition (ANEA) and AIDS United would like to provide a few comments and recommendations for their consideration. Overall, we at ANEA and AIDS United are in agreement with the general vision and mission of the National HIV Strategic Plan (HIV Plan) and believe it can serve as a productive foundation for the shared efforts of federal, state, and local governments, HIV service organizations and healthcare providers, and HIV advocates to end the HIV epidemic and raise the quality of life for all people living with HIV, particularly those who are Black, Brown and Indigenous, those who are over the age of 50, and those who are LGBTQ. Similarly, we are in agreement that both bolder targets and bolder strategies are required to end not only the HIV epidemic, but the STI, viral hepatitis, overdose, and COVID-19 syndemics as well. It will indeed take a “whole of society” approach integrating all aspects of federal, state, and local governments, as well as the private sector, to achieve our goals.

Having said all of this, we also believe that there are significant shortcomings and oversights in the recently released draft HIV Plan that must be addressed comprehensively and swiftly if we are going to end the HIV epidemic in the United States in the near future. Most of the issues we have found revolve around either a failure to incorporate meaningful involvement of people living with HIV into the infrastructure of the response outlined in the HIV Plan or a lack of specificity, planning, and focus on the needs of some of the most under-resourced, overlooked and stigmatized people in society: a) Black, Hispanic/Latinx, Indigenous, and other people of color living in America, b) Older people (50+) living with or impacted by HIV, c) people who use drugs, and d) people who engage in sex work.

We are happy to note that, with all of the populations listed above, our issues with the HIV Plan lie not in a total omission of these groups, but with the degree to which they are central to the plan itself and the absence of any concrete steps towards addressing the issues that matter most to them. It is not enough for a document like the HIV Plan to simply acknowledge the need to, “develop and implement effective, evidence-based, or evidence-informed interventions that address social and structural determinants of health among people with and at risk for HIV”. Instead, the HIV Plan must not only identify these broad, systemic issues and the need to address them, but also provide some concrete, actionable strategies for doing so. Below, we have outlined several items that could help to achieve this end if they were to be included in the HIV Plan.
I. Meaningful Involvement of People Living With HIV:
   A. Ensure that the strategies identified in Goal 3.3 create robust leadership pipelines for the HIV Plan priority populations that remove barriers to engagement from said populations by providing comprehensive and accessible training, multi-lingual leadership opportunities, and avenues for accountability from stakeholders at every level.

II. Explicitly call out systemic racism in the healthcare sector, and provide concrete strategies to advance racial equity and diversity across the HIV sector:
   A. In addition to the strategies identified in Objective 3.1 the HIV Plan must:
      1. Declare racism as a public health crisis and create community specific approaches to address medical mistrust among priority populations such as:
         a) Working with Black leaders to address and repair trust in US institutions by addressing the harm caused by a histories of medical malfeasance and the on-going police and state-sanctioned violence against Black people.
         b) Working with Hispanic/Latinx and other immigration leaders to address the human-rights violations occurring at the border and throughout US Immigration Custom Enforcement agencies as a way to prevent HIV, COVID-19, other transmittable viruses and build buy-in for the HIV Plan among migrant communities.
         c) Ensure federal employees have access to on-going racial and gender justice training that will prepare them to adequately serve the priority populations identified in the HIV Plan. No “one-size-fits-all” diversity training for federal agencies.
         d) Ensure that the leadership of trans and gender-conforming communities is prioritized across federal programs and invest in “whole society” approaches and funding for this community to stop the on-going violence against trans women of color.

III. Place a much greater emphasis on the needs of older people living with HIV and long term survivors:
   A. The Fenway Institute, SAGE, and other experts identified the needs of long-term survivors and those aging with HIV in their public comments to the HIV Plan. We echo their sentiment that present day elder service and care systems are unprepared to care for the needs of these communities and call for the HIV Plan to further integrate long term survivors and older people living with HIV throughout all of the Plan strategies.
IV. Provide considerably more resources and focus on the needs of people who use drugs.
   A. While we are appreciative that syringe services programs are cited as part of the “robust prevention toolbox” that should be used to lower HIV transmission risk, the HIV Plan needs to do considerably more to address the myriad threats and obstacles to healthcare and improved quality of life faced by people who use drugs.
   B. The HIV Plan should explicitly call for Congress to fully repeal the ban on federal funding for sterile syringes and other materials needed to reduce the risk of HIV transmission in injection drug use, and encourage state and local governments to follow scientific best practices in addressing the overdose crisis.
   C. As part of its emphasis on addressing the HIV epidemic with a whole of government approach, the HIV Plan should emphasize the need to connect all of the various federal agencies and offices who are engaged in addressing the overdose epidemic to engage them in federal efforts to end the HIV epidemic as well. Particular emphasis should be placed on connecting with the Substance Abuse and Mental Health Services Administration, the Office of National Drug Control Policy, the Indian Health Service, and the department of Housing and Urban Development.

V. Prioritize the provision of care and allocation of resources to people who engage in sex work.
   A. Sex work is mentioned only once in the entirety of the HIV Plan (Objective 3.1). This lack of attention to people who engage in sex work is wildly disproportionate to the increased risk of HIV faced by these communities.
   B. The HIV Plan should make a clear distinction between consensual sex work and sex trafficking. The federal government’s refusal to distinguish consensual sex work from the atrocity of sex trafficking exacerbates the HIV/AIDS epidemic through the money and time spent criminalizing people who trade in sex, often those most marginalized in our society. As sex workers have long called for, federal decriminalization of sex work will promote a public health response to the STI syndemic in our nation by directing resources to connection, testing, and treatment for people who engage in sex work while appropriately narrowing a law enforcement response only to situations of trafficking.
   C. The HIV Plan should call for increased leadership from the sex worker community and fund research that examines disparities among the HIV care continuum and other health outcomes for people who engage in sex work.

VI. Foster collaborations with HUD and create federal housing programs and safety nets that recognize Housing as Healthcare
A. In addition to the integration of data across programs to improve design and delivery of services called for in the HIV Plan, there is a need for an immediate call across federal agencies to prevent evictions until the COVID-19 pandemic is controlled.

   1. The HIV plan must further elevate how housing is a critical tool to help individuals achieve HIV viral suppression and integrate further research on housing is the key strategy to prevent other communicable illnesses such as COVID-19.

VII. HIV Criminalization

A. We are grateful that the Plan states that HIV-specific criminal laws perpetuate HIV-related stigma and discrimination. However, the plan does not call for enough immediate action to address the negative impacts of HIV Criminalization, which disproportionately impacts Black, Hispanic/Latinx, people of color, and transgender communities.

   1. The Plan must encourage the passing of legislation that ends HIV criminalization such as the REPEAL (Repeal Existing Policies that Encourage and Allow Legal) HIV Discrimination Act. Ending HIV criminalization across the nation is the most effective way to end the stigma and discrimination these laws perpetuate.

   2. The Plan should also call for the creation and review, with community input, of guidelines on the uses of HIV molecular surveillance (MHS). Such guidelines must restrict the access to MHS data from local, state, and federal policing and law enforcement agencies and should research its efficacy in helping to reduce transmissions.

Thank you for considering our comments. ANEA and AIDS United welcomes any future opportunities to support a HIV National Strategic Plan that truly elevates the needs and secures the leadership of the diverse HIV community. Please let us know how we can further bring the voice of the HIV community forward by emailing Edric Figueroa at ANEA (anea@treatmentactiongroup.org) and Drew Gibson at AIDS United (dgibson@aidsunited.org).

Sincerely,