

---

Presidential Advisory Council on  
**HIV/AIDS**

---



AUG - 8 2011

The Honorable Barack H. Obama  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

Dear Mr. President:

As members of the Presidential Advisory Council on HIV/AIDS (PACHA), we would like to thank you for the wonderful opportunity to serve the nation in addressing the HIV/AIDS epidemic, and to congratulate you for your outstanding leadership in releasing the National HIV/AIDS Strategy (NHAS) in July 2010. The NHAS has done much to reenergize the HIV/AIDS efforts in the U.S. and to promote a shared vision of where the nation needs to be by 2015.

While there is great support of the NHAS goals regarding HIV incidence reduction, treatment access expansion, disparities alleviation, and service coordination improvement, a tremendous amount of work must be done by 2015 to achieve these goals. PACHA respectfully requests that you indulge us an annual letter to describe what we see as some of the major successes over the prior year as well as the major challenges for the upcoming year which must be addressed to make NHAS goal achievement a reality. We have sent a more detailed letter to Secretary Sebelius (a copy of which is attached).

**Situational Analysis.** Since the beginning of the epidemic and through 2006, HIV prevention efforts in the U.S. have averted at least 350,000 infections and saved over \$129 billion in healthcare costs. In a given year in the U.S., over 95% of all persons living with HIV do not transmit the virus to anyone else (down from very high transmission rates early in the epidemic), thanks to testing, prevention and treatment efforts. Advances in HIV treatment have resulted in substantial reductions in death rates, and HIV may now rightly be considered a chronic disease. As of 2008, there were nearly 1.2 million persons living with HIV. Unfortunately, there are still approximately 50,000 HIV infections per year in the U.S. and there is still a death among persons living with HIV roughly every 33 minutes in the nation.

The HIV-related disparities are stunning with men who have sex with men (especially Black men who have sex with men), African-American, and Latino/Latina communities profoundly disproportionately shouldering the burden of this epidemic. Many women delay entry into care, and are less likely to begin antiretroviral therapy due in part to insufficient women-centered services, missed opportunities for linkages between various service delivery programs, and socioeconomic barriers to care (such as poverty). The financial consequences of the epidemic are also daunting as HIV care costs roughly \$20,000 to \$34,000 per client per year, depending on disease stage and provider.

Of course, the NHAS does an outstanding job of pointing us in a number of key directions that must be taken to more effectively address the prevention, care, disparities and program coordination aspects of the epidemic. We believe that in the coming year, the following areas are in need of priority attention:

**Supporting Full Access to Testing, Care and Prevention Services.** Approximately 20% of persons living with HIV are not aware of their HIV serostatus. Of persons diagnosed with HIV, only 75% are linked to HIV care, and only one-half are retained in care. Therefore, the AIDS Drug Assistance Program (ADAP) waiting lists (which now include over 8,650 people living with HIV) are just a small fraction of the unmet needs for HIV care in the U.S. We believe that additional efforts are urgently needed to ensure comprehensive access to testing, treatment, and prevention services in the U.S. (including protecting the Medicaid program from budget cuts given its critical role in meeting the care and treatment needs of low-income people living with HIV and other chronic medical conditions). It has been estimated in the literature that supporting the services necessary to meet the prevention goals of the NHAS would have an \$8:\$1 return on investment, sufficient to pay for the NHAS treatment expansion goals. We are grateful that you have worked hard to enact and implement the Affordable Care Act (ACA); yet we need additional short-term responses to ADAP waiting lists until 2014, and then longer-term efforts to address the other barriers such as inadequate engagement in care, late initiation of treatment, lack of sufficient support services, and poor adherence, many of which will become easier to address once insurance coverage is expanded by the ACA.

**Identifying Optimal Resource Allocation for Evidence-based Prevention Strategies.** The National Institutes of Health (NIH) and CDC have previously identified an array of evidence-based HIV prevention strategies (including HIV testing, behavioral interventions, condom distribution, syringe exchange, and structural interventions including housing). **We now have the very recent and critical findings from an NIH trial (called "HPTN 052") that early HIV treatment in HIV serostatus discordant couples can nearly eliminate transmission of the virus.** As a nation, we must make optimal use of this landmark finding of "treatment as prevention." However, given that so many people living with HIV in the U.S. do not have access to treatment (or do not know their HIV status), reaping the full potential of the HPTN 052 findings will be challenging. Indeed, over one-half million people living with HIV in the U.S. are not in HIV care, and therefore the translation of a finding from a landmark clinical trial on "treatment as prevention" into a population level effect poses substantial operational and resource allocation challenges that must be addressed in the coming year.

**Transforming Expensive Reporting Requirements Into a Strategic Management Dashboard.** Health Departments receiving federal HIV/AIDS funding are now burdened with nearly ninety separate reporting requirements (including reporting on hundreds of specific variables). Sadly, the large quantity of this information has not yielded the optimal quality data needed for program evaluation and management. Therefore, we urge that a streamlined, strategic dashboard be finalized over the coming year. Utilizing just a handful of very well-chosen metrics that are relevant and comparable across federal funding sources, this dashboard should emphasize

program transparency, accountability, and allow for strategic mid-course corrections to ensure achievement of the NHAS goals.

**Support of Transfer Authority for Strategy Implementation Fund.** We applaud your seeking of Congressional approval for transfer authority to create a Strategy Implementation Fund to be used at the discretion of the Secretary. This fund will address critical unmet needs, and support the gathering of information and conducting of analyses necessary to ensure that *all* federal HIV/AIDS efforts make their maximum contribution to the NHAS goals. We support the fund's maintenance and potential expansion.

**Addressing HIV-Related Health Disparities in the U.S.** The NHAS rightly decries the substantial stigma and discrimination faced by persons living with HIV. It is shocking that thirty years into the epidemic, we still see such social injustices in the nation. While we believe that addressing inequities in funding patterns is key to lessening HIV-related disparities, even more profound progress will be made when the root causes of HIV-related stigma are also confronted. Addressing stigma will also require tackling HIV criminalization - the use of the criminal law to target and punish those who are HIV seropositive for consensual sex and conduct that poses no risk of HIV transmission.

**The Domestic/Global Interface of the HIV Epidemic.** The U.S. HIV epidemic is inextricably woven into the global epidemic. America's efforts to tackle the global AIDS epidemic through PEPFAR and the Global Fund have had profound impact and laid the foundation for the Administration's Global Health Initiative. However, new resources and portfolio realignment are necessary to take advantage of the connection between HIV treatment and prevention and to scale up these proven evidence-based approaches in our international efforts. We have a moral imperative to turn the tide of the AIDS pandemic globally as it devastates individuals, families, communities, and society at large – possibly threatening our national security as 50 million children worldwide could be left parentless by 2020 without bold action.

We thank you most sincerely for taking the time to consider our reflections and recommendations, and would be pleased to hear from you on how we might be of optimal service to your Administration. We take very seriously our roles as members of PACHA and are eager to tackle tasks that you would find informative and useful. We all share your intense commitment to addressing the HIV epidemic in the U.S. and across the globe; indeed, we have all devoted our lives to ending this epidemic.

With greatest respect and appreciation,

*David Haltyrave, for*

Helene Gayle, MD, MPH

Chairperson

Presidential Advisory Council on HIV/AIDS

Enclosure