HIV Prevention for Gay Men & Men Who Have Sex with Men:
Development of a Comprehensive Policy Agenda
October 26, 2010

Summary of Consultative Meeting

The President released the National HIV/AIDS Strategy (National Strategy) in July 2010 with an aim to reduce new HIV infections, increase access to care for people living with HIV and to reduce HIV-related health disparities in the United States. Although the National Strategy identified several priority populations, the document specifically cited CDC surveillance data that reported that gay and bisexual men are the only population in the U.S. where new cases of HIV are rising. In response, amfAR, the Foundation for AIDS Research and the Trust for America's Health (TFAH), supported by funding from the M·A·C AIDS FUND, convened a meeting of experts on October 26, 2010, to:

- Develop a comprehensive public policy agenda to more effectively prevent HIV transmission among gay men and other men who have sex with men (MSM).
- Engage HIV/AIDS and gay health advocates to re-think and improve current methods of prevention.
- Provide guidance to decision-makers on how to formulate the most effective HIV prevention strategy.

The convening focused on population activities and context in an attempt to reach the above goals. **While efforts to modify individual risk behaviors remain valuable, there was consensus that focusing solely upon individual behavioral interventions is insufficient. Environments that present risk of facilitating HIV transmission and ways to re-structure those settings to impede viral exposure must be the focus of new policy initiatives.**

Indeed, an overarching message from the convening was on the need to move away from just HIV-specific interventions, to structural interventions (including harm reduction), health systems interventions, and policy strategies to promote HIV risk reduction within the broader context of **promoting healthy lives for gay men**.

Framework for HIV Prevention among Gay Men

The meeting was framed by a background document, which emphasized this larger opportunity for changing the risk environment and creating healthier lives for MSM. There was general agreement that there is not one "magic bullet" that would create this healthier environment, but a combination of approaches that would address many factors including:

- *Community viral load* – By understanding the level of viral load in geographic areas and within sexual networks, it may be possible to intervene to lower transmission risks associated with episodes of unprotected sex.
- *HIV Status and Treatment Access* – Different behavior patterns are apparent for men who are HIV-diagnosed, have tested negative for HIV, or have unknown serostatus. These differences underscore the

potential for improved serostatus targeting of prevention programs. Capturing the prevention benefits of antiretroviral therapy depends on timely diagnosis of HIV, swift and sure linkage to high-quality care, timely administration of effective antiretroviral regimens, continuity of care, and strong treatment adherence.

- *Relationship Status* – Few prevention programs are targeted based on the relational status of gay and bisexual men. Data indicate that primary partnerships may be responsible for two-thirds or more new HIV infections. Although many couples aim to reduce their HIV risks through negotiated safety, this approach is often imperfectly implemented.
- *Syndemics* – A notable minority of gay men experience multiple, inter-related medical and psychosocial issues that both reflect and increase their vulnerability to infection. Key issues include drug and alcohol abuse, depression and other mental health issues, prior experience of sexual abuse, and victimization by violence. Addressing syndemics requires more than provision of services, but also tackling the structural causes associated with the risk-related issues– including racism, constructs around masculinity, and homophobia. These strategies must also take into account culturally specific contexts for Black and Hispanic gay men. Employment of non-discrimination and zero tolerance for anti-gay bullying in schools are examples of the kinds of policy reforms needed to address social factors in vulnerability.
- *Situational Factors* – The Internet, bathhouses, and sex clubs may facilitate multiple sex partners but the degree to which they encourage sexual behavior that increases the risks for HIV transmission (e.g., unprotected sex between serodiscordant partners) is not always clear. Although they present opportunities to provide testing and prevention services, a significant number of gay men are using the Internet and GPS-related technology to find sex partners which are currently beyond the reach of conventional prevention services.
- *Harm Reduction* – Although prevention programs tend to treat the universe of sexual behavior as consisting of "safe" or "risky" components, sexual behaviors for gay and bisexual men exist along a continuum of risk. Many gay men are experimenting with strategies to reduce their risk, but often doing so without sound evidence or the guidance of public health officials or community-based prevention programs.
- *Community Issues* – Prevention programs have generally failed to capitalize on the well-documented resiliency of gay men. Overwhelmingly focused on individual behavior change, prevention efforts in recent years have seldom targeted broader community norms or institutions. Prevention campaigns should be created with the input of the targeted community to assure cultural appropriateness and to avoid pathologizing in the name of addressing norms.
- *Biomedical Approaches* – Existing or potential options exist to reduce the physiological likelihood that an episode of unprotected anal intercourse will lead to infection. These options include pre-exposure prophylaxis (for HIV-negative MSM), post-exposure prophylaxis (for HIV-negative MSM), test-and-treat approaches (for undiagnosed HIV-positive MSM), and treatment of STDs (for MSM generally). Recent research demonstrating the efficacy of PrEP in gay men (when used in combination with other interventions) raises significant hope, tempered by questions related to adherence, the potential for increased risk taking, long term safety, and how to operationalize a PrEP program.

The discussion of these issues was primarily focused on federal policy and with the recognition that the federal government does not have unlimited resources to implement these new approaches. That said, there was general agreement among the non-federal representatives that both new resources and realignment of existing resources would be needed to achieve this new approach to HIV prevention among gay men.

Changing the Risk Environment through Reduced Community Viral Load

While there was a general view that addressing community viral load is a promising approach, some key issues were identified that need to be resolved before this could be embraced as a national policy. They include:

- Surveillance capacity: Do states or localities have the capacity to collect and/or analyze the data? What are the most important data to have for best targeting interventions? What evaluation measures should be used to determine the success of a community viral load intervention? Are there dangers in targeting neighborhoods too narrowly given differences between where people live and have sexual encounters?
- States and localities would need technical assistance in both creating the political support for viral load surveillance and adopting the health information technologies that are associated with effective implementation of this approach.
- Expanded HIV testing, linkage to care, and adherence to care are essential to the success of a community viral load approach. Indeed, measurement of community viral load has a fundamental gap– it only reflects data on people who are already identified as HIV infected and have some linkage to the care system. Bringing the missing 21 percent of people with HIV who don't know their status into the system – and keeping them there – will require a separate, but related, set of initiatives. Higher rates of undiagnosed and untreated HIV infection among particular groups at elevated risk, including Black gay men, point to the need to design, fund and evaluate programs that can be more successful at reaching these groups with testing, linkage, care and prevention services.
- Routine HIV testing becomes part of the standard of care among public providers and through public financing programs. This includes:
    - Making routine HIV screening part of the standard of care at Community Health Centers.
    - Making routine HIV screening part of the standard of care at all SAMHSA funded sites providing substance abuse and/or mental health services.
    - Making routine HIV screening a high profile policy within the Medicaid program, including an emphasis on emergency department encounters.
- To assure appropriate linkage to care and adherence to care several steps could be taken, all of which recognize the fact that prevention and treatment are part of a single continuum. Among the policy changes considered were:
    - Integration of the HIV prevention and HIV care services planning processes at the state and local levels.
    - Permit blending of CDC, HRSA, and SAMHSA funding streams – either literally or through a virtual blending (by simplifying reporting requirements and adopting common eligibility criteria, among other things).
    - The CDC, in implementing the community health workers program authorized in the Affordable Care Act and likely to be initiated in FY 2011, could include an initiative that focuses on linking people at risk to testing and care and assuring adherence for those already in care.
    - Adequate coverage of HIV care and drugs. The best testing, linkage, and adherence approaches will only work if people with HIV truly have ready access to HIV treatment. The shortfalls in ADAP are the most visible threat to successful implementation of the strategies described above.

Addressing the Social and Behavioral Determinants of Risky Behavior by Gay/Bisexual Men

Efforts to reduce the risk environment (such as reducing community viral load) must be complemented by efforts at reducing risk taking by the individual. Public health has a responsibility to provide the best possible information to individuals about risk, so they can make informed choices. This is particularly true with regard to behaviors such as serosorting and specific sexual practices.

However, a focus strictly on HIV risk or sexual health or risk taking among MSMs does not fully address the behavioral determinants of risk taking, the often deeply embedded factors that are usually non-sexual in origin that result in higher risk taking. The literature suggests that these range from experience of bullying and other forms of stigma in adolescence and beyond, experience of sexual violence, domestic violence, depression and

other mental health issues, and substance use. Without **a syndemic approach**, we are not going to address the fundamental behavioral determinants of HIV-related risk taking among gay men.

One particular opportunity to address this broader approach to healthier lives for gay men is through the newly-created **Community Transformation Grants**, expected to start in FY 2011. These grants are designed to address policy and structural changes that can promote healthier lives, with an emphasis on addressing disparities. CDC has an opportunity to develop a package of interventions that communities (state or local health departments or community based organizations) could adopt to target changing the risk environment for gay men.

It should be noted that programs and policies need to reflect the many aspects of diversity in the gay community: race/ethnicity (including the fact that the experience of gay men of color is not uniform – community and social factors affecting Hispanic gay men are often quite different from African American gay men); age (differing supports and experiences run the lifespan, from gay youth to gay elders); class; and relationship status. In some cases, Institutional Review Board policies place limits on inclusion of young gay men in health research, complicating efforts to develop appropriate interventions for this group.

The responsibility and opportunities for creating a healthier environment for gay men is not limited to health agencies. The Department of Education's recent initiative around enforcement of anti-bullying policies is an example of policy change that can enhance the social support for gays that addresses some of the factors associated with risk taking later in life. Other examples of policy and risk environment change identified include:

- The existence of stigma and discrimination surrounding HIV infection; being gay in some communities; and the role shame plays in the broader gay and general community;
- Limited access to comprehensive and early sexual education;
- Inadequate programs and support systems for MSM individuals and their families-particularly those of color;
- Mistrust and differing perspectives of the medical profession persist (particularly in communities of color);
- Lack of primary care services to provide culturally appropriate and effective care for gay men;
- Community resilience as a foundation for HIV prevention remains largely unexplored by well-designed studies; and
- Prevention research efforts need to examine broader cultural issues (e.g. the deleterious effects of anti-gay ballot measures on mental health, the role of shame in the lives and sexual decision-making of gay and bisexual men, and the contribution of prior sexual abuse to increased sexual risk-taking).

Maximizing the Potential of the Affordable Care Act to Enhance Prevention and Treatment of HIV

Several key elements associated with implementation of the Affordable Care Act were identified as providing opportunities to enhance access to appropriate services for gay men at risk for HIV. These include:

- Assuring appropriate coverage of preventive services. Work is needed to harmonize recommendations by the CDC and the US Preventive Services Task Force (USPSTF), either through adoption of the CDC's recommendations by the USPSTF or by inclusion of CDC recommendations as part of the Essential Health Benefits package defined by the Secretary of Health and Human Services.
- Assuring access to comprehensive care and support services through inclusion of the HHS HIV/AIDS treatment guidelines as part of the Essential Health Benefits package and using the Ryan White model of holistic HIV/AIDS service delivery as a standard for the newly-created Accountable Care Organizations, medical home models, and the Medicaid health home. Steps should be taken to assure that Ryan White providers are part of these initiatives. In addition, HIV experienced providers should be required to be part of

any network included in any private plan included in a Health Insurance Exchange, along with public health departments that provide HIV services (including HIV testing) and appropriate Ryan White providers.

- Assure that the new Health Information Technology (HIT) system has the capacity to provide critically important information about the HIV epidemic and the provision of services.
- Assure that immediate changes under the Affordable Care Act are used to improve access to and quality of care including maximizing use of the new Pre-existing Condition Insurance Plan and using the new workforce initiatives to expand the number of HIV providers and improve the LGBT-related cultural competence of health providers in general.

December 9, 2010

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October 26, 2010
8:30am – 4:30pm
The Renaissance Washington, DC DuPont Circle
Washington, DC

Confirmed Participant List*

Urooj Arshad	Associate Director	Advocates for Youth
Cornelius Baker	Senior Communications Advisor Center on AIDS & Community Health	AED
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Kevin Cranston	Director, Bureau of Infectious Disease	Massachusetts Department of Public Health
Julie Davids	Co-Director	Community HIV/AIDS Mobilization Project (CHAMP)
Diana Echevarria	Executive Director	M·A·C AIDS Fund
Tam Ho	Director	M·A·C AIDS Fund
Kali Lindsey	Senior Director of Federal Policy	Harlem United Community AIDS Center, Inc.
Manya Magnus	Associate Professor, Department of Epidemiology and Biostatistics & Assistant Professor, Department of Health Policy	George Washington University, School of Public Health and Health Services
Stephen Massey	Associate Director, Entertainment Media Partnerships	Kaiser Family Foundation
Ken Mayer	Professor of Medicine and Community Health and Director, Brown AIDS Program	Brown University
Mazdak Mazarei	HIV Program Capacity Building Specialist	Asian & Pacific Islander American Health Forum
Bill McColl	Political Director	AIDS Action
Britt Rios-Ellis	Director	NCLR/CSULB Center for Latino Community Health
Ron Stall	Professor and Chair, Department of Behavioral and Community Health Sciences	Graduate School of Public Health, University of Pittsburgh
Tyler TerMeer	Prevention Program Manager, Gay Men's Portfolio	National Association of State & Territorial AIDS Directors
Wakefield	Associate Director for Community Relations	HIV Vaccine Trials Network
Patrick Wilson	Assistant Professor of Sociomedical Sciences	Mailman School of Public Health, Columbia University
Observers		
Jeff Crowley	Director of the Office of National AIDS Policy and Senior Advisor on Disability Policy	The White House

John Douglas	Chief Medical Officer, National Center for HIV, Viral Hepatitis, STD, and TB Prevention	Centers for Disease Control and Prevention
Cynthia Grossman	Program Officer	National Institute of Mental Health/NIH
Deborah Parham Hopson	Associate Administrator, HIV/AIDS Bureau	Health Resources and Services Administration, U.S. Department of Health and Human Services
Jono Mermin	Director, Division of HIV/AIDS Prevention	Centers for Disease Control and Prevention
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Note that this list is for informational purposes only and does not mean to imply that these individuals or organizations support the totality of this document.