

18-02

STATEMENT OF POLICY

HIV Prevention, Care, and Treatment

Policy

The National Association of County and City Health Officials (NACCHO) recognizes the ability to end the HIV epidemic in the United States and encourages coordination and collaboration among federal, state, local, and community stakeholders to achieve this goal. As implementers, coordinators, and partners in providing and assuring high-quality HIV prevention, care, and treatment, local health departments are essential to improving outcomes across the HIV care continuum and working toward zero new infections.

NACCHO urges increased federal, state, and local funding to support state and local health department implementation of evidence-based programs and policies for HIV prevention, care, treatment, and surveillance. Further, funding must be allocated equitably to ensure necessary resources where HIV burden is greatest. NACCHO opposes the repeal of the Affordable Care Act (ACA) as well as actions to erode coverage and essential benefits, as these actions will have adverse effects on the lives of people living with and affected by HIV.

Additionally, funding for the Ryan White HIV/AIDS Program (RWHAP) must also continue to ensure that low income, uninsured, and underinsured people living with HIV have access to the core medical and support services that are vital to achieving and maintaining viral suppression, thus contributing to improved health outcomes, as well as a public health approach to reducing new HIV infections.

NACCHO encourages local health departments to take the following actions toward ending the HIV epidemic in their jurisdictions:

- Engage community members and other key stakeholders in the development, implementation, and evaluation of strategies and plans to end the HIV epidemic.
- Develop and sustain strong partnerships and collaborations to better coordinate and enhance the quality of local HIV prevention, care, and treatment services.
- Make HIV testing easy, accessible, and routine, and assure timely, accessible, affordable, and comprehensive systems of HIV care and treatment. This is critical given that people living with HIV who achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner.
- Support implementation of high-impact HIV prevention using combinations of scientifically proven, cost-effective, and scalable interventions, including biomedical interventions including post-exposure prophylaxis (PEP), pre-exposure prophylaxis



(PrEP), treatment as prevention (TasP), and harm reduction strategies, such as syringe service programs (SSPs).

- Support the Undetectable = Untransmittable (U=U) campaign, which aims to raise awareness about the effectiveness of HIV treatment and destigmatize HIV.
- Provide HIV education and outreach to healthcare providers and community members, inclusive of epidemiologic data, evidence-based and informed prevention and care strategies, efforts to advance health equity, and population-specific needs and considerations.
- Enhance coordination and integration efforts between HIV programs and services and behavioral and mental health, substance use, primary care, sexually transmitted infections, viral hepatitis, and other interrelated issues to comprehensively address the needs of people living with and at risk for HIV.
- Strengthen local data systems to improve the timeliness and usability of data to inform HIV prevention, care, and treatment decision-making, planning, and programming.
- Promote health equity through HIV efforts by addressing the social determinants of health that contribute to the root causes of health inequities by undertaking cross-sector approaches and implementing strategies to reduce stigma and eliminate discrimination.

Across all of these actions, it is critical that local health departments address the specific needs of highly impacted populations, including communities of color, gay and bisexual men, cisgender women, transgender women and men, youth, and people who inject drugs (PWID). Further, it is vital that local health departments work with community partners to create and ensure services and environments that are safe, inclusive, and foster hope and healing. NACCHO opposes all forms of stigma, discrimination, and punitive measures against people living with HIV, and recommends that state legislatures review HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV.

Lastly, NACCHO urges increased federal funding to support research for an HIV cure, HIV vaccine, improved treatment regimens, expanded prevention strategies, and implementation science.

Justification

The HIV epidemic continues to be a major public health problem in the United States and globally. In the U.S., an estimated 1.1 million people are living with HIV and of those, 162,500 (15%) have not been diagnosed. Young people, ages 13-24, are the most likely to be unaware of their status.¹ There were 39,782 new HIV infections and 18,160 AIDS diagnoses in 2016, with a disproportionate number of infections occurring in the South. Southern states accounted for more than half of the new HIV diagnoses in 2016 and 44% of all people living with HIV, while making up 38% of the national population.² Health disparities are pervasive throughout the country, but are particularly heightened in the South, where minorities continue to be disproportionately impacted by HIV. Using the framework of the HIV care continuum to measure and monitor progress, CDC estimates that of those diagnosed with HIV in the United States, 85% are aware of their diagnosis, 62% are engaged in HIV medical care, 48% are retained in care, and only 49% are virally suppressed. Despite decreases in new infections from

2011–2015, progress by some populations remains uneven. And, despite advances in treatment, each year thousands of HIV-attributed deaths still occur.²

About 70% of annual HIV infections are among gay and bisexual men and 44% of all new HIV diagnoses are among African Americans, who make up 12% of the U.S. population.³ An alarming analysis by the Centers for Disease Control and Prevention (CDC) suggests that if current HIV diagnosis rates persist, one in two black men who have sex with men (MSM) and one in four Latino MSM will be diagnosed with HIV in their lifetime.⁴ Transgender people, particularly transgender women, are vulnerable to HIV infection. Available evidence suggests that, in relation to their population size, transgender women are among the most heavily affected populations in the United States. Gaps in knowledge about population size and trends in HIV infections, however, create significant challenges to designing effective prevention programs, directing resources, and tracking progress in this population. In an analysis of CDC-funded HIV testing conducted nationwide, transgender women had the highest rates of HIV diagnoses (2.7%), followed by men (0.9%), transgender men (0.5%), and women (0.2%). A 2013 meta-analysis of available research estimated that 22% of transgender women were living with HIV in five high-income countries, including the United States. Transgender women of color are known to be especially vulnerable to HIV infection. For example, data from New York City show that between 2010 and 2014, 234 transgender people received a diagnosis of HIV infection. Nearly all (99%) were transgender women, of whom 93% were black/African American or Hispanic/Latino.⁵ For PWID, HIV diagnoses declined 48% from 2008 to 2014. However, injection drug use in nonurban areas has created prevention challenges and has placed new populations at risk for HIV. If current rates continue, 1 in 23 women who inject drugs and 1 in 36 men who inject drugs will be diagnosed with HIV in their lifetime.⁶

Tremendous progress against HIV/AIDS over the past 15 years has inspired a global commitment to end the epidemic by 2030.⁷ Today, more tools than ever are available to prevent HIV and there is evidence to show that if a person living with HIV is virally suppressed, there is effectively no risk of sexually transmitting the virus to an HIV-negative partner.⁸ The Food and Drug Administration's approval of Truvada (tenofovir disoproxil fumarate plus emtricitabine) for use as PrEP in 2012 welcomed in a new era for biomedical HIV prevention. In May 2014, the U.S. Public Health Service released the first comprehensive clinical practice guidelines for PrEP.⁹ When taken as prescribed, daily oral PrEP reduces the risk of HIV acquisition by more than 90%. While PrEP is a proven prevention strategy, the uptake is mostly among white men age 25 and older, meaning that the risk groups at the very highest of infection, namely young black MSM, are still not benefiting significantly from this highly effective form of HIV prevention.¹⁰ Implementation of PrEP has re-introduced a focus on PEP, the intervention of taking antiretroviral medicines after being potentially exposed to HIV to prevent becoming infected. PEP should be used only in emergency situations and must be started within 72 hours after a recent possible exposure to HIV. PEP is effective in preventing HIV when administered correctly.

People with HIV who are aware of their status can get HIV treatment (antiretroviral therapy, or ART) and remain healthy, living a near normal lifespan. Studies show that the sooner people start treatment after diagnosis, the more they benefit from ART. Treatment with ART lowers the level of HIV in the blood (i.e., viral load), reduces HIV-related illness, and lowers the risk of

transmitting HIV to others. This highlights the importance of HIV testing and timely access to HIV care and treatment for the individual, but it also has a public health impact as it relates to supporting reduced HIV transmission (i.e., TasP). Research convincingly shows that when a person living with HIV is on effective treatment, it will reduce the level of HIV to “undetectable” levels, which effectively makes them incapable of transmitting HIV to their sexual partners. Across three different studies (HPTN 052, PARTNER, and Opposites Attract),¹³ including thousands of couples and many thousands of acts of sex without a condom or PrEP, no HIV transmission to an HIV-negative partner were observed when the HIV-positive person was virally suppressed. This means that people living with HIV who achieve and maintain an undetectable viral load have “effectively no risk” of sexually transmitting the virus to an HIV-negative partner.¹²

Launched in 2016 by Prevention Access, the Undetectable = Untransmittable (U=U) Campaign has gained worldwide traction and galvanized support for updating language, policies, and programs to fully reflect the science. As of February 2018, U=U had over 575 community partners from 74 countries, including the United States.¹¹ U=U is an important opportunity to transform the lives of people living with HIV and the field. It aims to reduce the shame and fear of sexual transmission and opens up possibilities for conceiving children without alternative means of insemination; dismantle HIV stigma on the community, clinical, and personal level; encourage people living with HIV to start and stay on treatment to keep them and their partners healthy; and offer a strong public health argument for universal access to diagnostics, treatment, and care to save lives and bring us closer to ending the epidemic. U=U is helping to change the narrative around HIV and unite partners around the world to ensure that the science we know reaches the people in the field it is intended to benefit. Local health departments and their community partners can sign onto the U=U consensus statement and use the messages and resources developed by Prevention Access in their communities.

In addition to these scientific advances, changes in the healthcare system have had a transformative impact on improved access to HIV care and treatment. Through the ACA, healthcare coverage has been extended to millions of Americans, and people with HIV saw significant gains in insurance coverage. The ACA broadened Medicaid eligibility, allowing more individuals with HIV to access care early. As of 2014, Medicaid covered four in ten individuals with HIV in care.¹⁴ An analysis by the Kaiser Family Foundation found that 62% of people living with HIV live in the 32 states, including the District of Columbia, that expanded Medicaid coverage, and that Medicaid expansion drove a decrease in uninsured individuals with HIV, an outcome not seen in non-expansion states.¹⁴ Additionally, the ACA has increased access to insurance by eliminating barriers, such as denial of health insurance based on pre-existing conditions, and through the coverage of preventive services, including HIV testing.

At the same time that Medicaid has expanded health insurance coverage for people living with HIV, many continue to rely on the RWHAP. The RWHAP continues to serve as an important safety net and funds gaps in coverage for those living with HIV/AIDS who are either uninsured or underinsured, which is especially important in states that have not expanded Medicaid. The RWHAP provides a comprehensive system of care that includes primary medical care and essential support services. It provides funding to cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each

year.¹⁵ The RWHAP reaches approximately 52% of all people diagnosed with HIV in the U.S.¹⁵ HIV outcomes among clients served by the program are better than those experienced overall, especially as it pertains to viral suppression. In 2016, 84.9% of Ryan White clients had achieved viral suppression, compared to 49% among all people living with HIV. In addition to funding medical and support services, the RWHAP also provides funding for technical assistance, clinical training, and the development of innovative models of care that address the needs of different communities and populations affected by HIV.¹⁶

People living with and at risk for HIV are disproportionately impacted by a number of co-morbidities that must be taken into consideration when designing and providing prevention, care, and treatment efforts. For example, about one in ten people living with HIV are coinfecting with hepatitis B virus and about one in four people are coinfecting with hepatitis C virus (HCV).¹⁷ Co-morbidities such as mental health and substance abuse not only affect the overall health and wellbeing of people living with HIV, but can lead to worse HIV outcomes, such as the ability to achieve and maintain viral suppression. The same behaviors that put people at risk for HIV also put them at risk for other health issues, such as acquisition of other sexually transmitted infections. As such, the coordination and integration of efforts among HIV programs and other services is critical to HIV prevention, care, and treatment efforts.

The 2015 HIV outbreak in Scott County, Indiana dramatically demonstrated the infectious disease consequences of the opioid epidemic, which is fueling the increase in injection drug use.¹⁸ While this HIV outbreak was unprecedented, the conditions that led to the outbreak are not unique. Responding to the outbreak in Scott County was an enormous effort that included local, state, and federal agencies, and one that will go on for decades to ensure care and treatment for those who were infected, and comprehensive prevention services for those that remain at risk for HIV and HCV (more than 90% of those infected with HIV during the outbreak were co-infected with HCV). In response to the HIV outbreak in Scott County, the CDC conducted an assessment to identify counties that might be particularly vulnerable to the rapid spread of HIV and HCV among PWID.¹⁹ The analysis identified 220 counties in 26 states as being most vulnerable to new HIV or viral hepatitis infections due to unsafe injection drug use. It is critical that state and local health departments further explore this vulnerability and implement harm reduction strategies, such as SSPs, to prevent the spread of HIV and viral hepatitis.²⁰

The National HIV/AIDS Strategy for the United States (NHAS) provides a roadmap for a coordinated national response to the HIV epidemic. Initially released in 2010 and updated in 2015, NHAS sets forth a vision, goals, and metrics for collective action across the country. NHAS is structured around four goals: reducing the number of new infections, increasing access to care and improving health outcomes for people living with HIV, reducing HIV-related disparities and health inequities, and achieving a more coordinated national response to the HIV epidemic. A recent study estimates that by reaching NHAS targets for HIV testing, treatment, and expanded use of PrEP, approximately 185,000 new HIV infections in the U.S. by 2020 could be prevented. This would account for a 70% reduction in new infections according to CDC.²¹

NHAS also highlights the importance of efforts to reduce HIV-related disparities and health inequities by implementing structural approaches to reduce the risk of HIV transmission at community and societal levels by addressing the social determinants of health, such as

suboptimal housing, education, and employment opportunities. Taking concrete steps to end stigma and discrimination at all levels is a critical step in decreasing barriers to HIV prevention, testing, care, and treatment. The steps to end stigma and discrimination must include standing against unjust HIV criminalization laws. HIV criminalization exacerbates stigma against people living with HIV and disenfranchised communities.²² It discourages those at risk from getting tested for HIV and some people living with HIV from seeking treatment, making it more difficult to disclose one's HIV positive status.²² About two-thirds of states have HIV specific statutes that result in prosecution of people living with HIV for having sexual contact without being able to prove they disclosed their HIV positive status in advance.²²

To effectively address stigma and discrimination, it is critical that the community be involved in HIV prevention, care, and treatment planning and program implementation. Further, inclusive care and treatment is vital in reaching viral suppression among priority populations most affected by the burden of HIV; thus, it is critical that local health departments engage these communities. Members of different communities, especially people living with HIV and at-risk subgroups, are in the best position to make decisions about the approaches to treatment, prevention, and testing that will be most effective in their communities.²³ Treatment and prevention literacy is a community-based activity that helps people learn factual evidence-based information in a non-threatening manner, thus addressing stigma and discrimination, as well as myths about these issues in the community.²³ It is important to engage the community to dispel myths and support changes in how cultures approach prevention.²³ The community is a highly regarded asset in the delivery of high-quality and culturally competent HIV services.

Progress in responding to HIV in the U.S, has opened a new era of working towards ending the HIV epidemic by getting to zero new infections. To help chart the course to achieving this goal, a growing number of U.S. cities and states have developed jurisdiction-specific plans to end the HIV epidemic. Additionally, as of January 2018, over 15 U.S. cities have joined the Fast-Track Cities Initiative, which supports the UNAIDS Fast-Track Strategy to end the AIDS epidemic by 2030.²⁴ Across all these strategies and initiatives, the role of local health departments—in collaboration with their community partners and stakeholders at all levels of government and across sectors—is critical to success, as are addressing health disparities, strengthening our public health and healthcare infrastructure, and assuring appropriate funding.

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Record of Action

Proposed by NACCHO HIV/STI Workgroup

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