May 2016

Revitalizing the United States Response to End AIDS as an Epidemic

- **Commit to end AIDS as an epidemic in the United States by 2025**, by dramatically reducing new infections, ending AIDS deaths and eliminating disparities in access to quality HIV prevention and treatment. Develop and fund a national blueprint for federal action to scale up evidence-based prevention, care and supports in order to reduce the number of new HIV infections each year to 12,000 or less by 2025.

- **Pledge new funding to end the global AIDS pandemic by 2030,** increasing the budget of the President's Emergency Plan for AIDS Relief (PEPFAR) by at least $2 billion per year by 2020 and supporting at least one-third of the fully-funded new financing for the Global Fund to Fight AIDS, Tuberculosis, and Malaria. This funding would double the number of people directly supported by the U.S. on treatment as part of leading a global plan to treat over 30 million people by 2020, and scale up combination prevention.

- **Maintain U.S. leadership in HIV research** by committing to substantial increases in National Institutes of Health (NIH) biomedical research funding overall, including sustained, scientifically grounded funding for the NIH HIV/AIDS research program while making resulting medical technologies available and affordable for all patients in need in the U.S. and in developing countries.

- **Ensure access to medicines for all** by supporting trade and other policies that reduce intellectual property barriers to medicines rather than raise them. In particular, we ask the next President to pledge to stop the Trans-Pacific Partnership, U.S. pressure on India (the pharmacy of the poor), and trade threats under the Special 301 Watch List.

- **Appoint an HIV advisor for your campaign** and transition team to learn from and work with members of the HIV community in the varied regions of the U.S. and its territories, and around the globe.

As President Obama observed in his final State of the Union address, “we’re on track to end the scourge of HIV/AIDS. That's within our grasp.”

With highly effective antiretroviral therapy, taken as treatment or prevention, we now have the means to end the global and U.S. HIV epidemics, even without a vaccine or a cure, by dramatically reducing new HIV infections and eliminating AIDS deaths. However, HIV continues to be a major public health burden in the U.S. and around the world, disproportionately affecting vulnerable populations, especially men who have sex with men (MSM), transgender individuals, people who use drugs,

sex workers, girls and young women, and other marginalized populations. We must bring available treatment and prevention tools to scale now to have the necessary impact on the epidemic; the intensity and scope of service delivery programs matters greatly and is an area in need of real attention.

The next U.S. President has an urgent opportunity to take historic action with a more aggressive global HIV response and a deeper federal commitment to end the national HIV/AIDS epidemic. Failure to act swiftly at the required scale will result in more HIV infection, more HIV-related morbidity and mortality, continued human rights violations and health inequities, and increased costs.

Lead the way by committing to end the U.S. AIDS epidemic by 2025

We call upon the next President to lead the global fight against AIDS by committing to end AIDS as an epidemic in the U.S. by the year 2025 and establishing a national strategy to end the U.S. HIV/AIDS epidemic as a key Year One priority.

In 2010, the White House Office of National AIDS Policy (ONAP) issued the first *National HIV/AIDS Strategy for The United States* (the NHAS), which envisioned the United States as "a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination." With implementation of the Affordable Care Act and advances in HIV treatment and prevention, the next President has the opportunity to realize this ambitious vision for the U.S. HIV response.

While there is still neither a vaccine nor a cure for HIV infection at hand, we now have the knowledge and means to *dramatically* reduce new HIV infections and promote optimal health for all those with HIV via concerted and coordinated efforts by community-based organizations, government, people with HIV, clinicians and service providers to increase the scale and reach of quality HIV prevention and care. The medications that dramatically improve quality of life for persons with HIV both suppress viral load and prevent transmission to others. Highly affected urban centers like New York City and San Francisco are using comprehensive prevention and care strategies to make dramatic progress towards realistic goals to end their HIV epidemics as early as 2020. Yet our national HIV response is stagnated, with the CDC estimating little or no reduction in the past decade in the 40,000 to 50,000 avoidable new HIV infections each year. *Indeed, some communities and regions are losing ground in the fight, with tragically increasing rates of new infections in the Southern states, among young MSM and women of trans experience, and in low-income communities of color*.

Set interim and 2025 public health goals for ending the U.S. AIDS epidemic.

To set benchmarks and goals for a U.S. plan to end the HIV epidemic, it is useful to consider a consider a scenario in which the number of new infections each year (incidence) finally drops below the annual number of deaths among persons living with HIV, eventually reducing the number of people living with HIV in the US (prevalence). Achieving this will be an important milestone toward ending the HIV epidemic.

Outlined below are ambitious but achievable goals for reducing annual incidence to 12,000 or fewer new HIV infections in the U.S. by 2025. A goal of less than 12,000 new infections is less than current estimates of all-cause mortality among persons living with HIV in the US, and also less than projected 2025 estimates of such mortality factoring in a declining death rate. Thus reducing the number of new HIV infections to 12,000 or less will change the trajectory of the epidemic from the year 2025 so that the number of persons living with HIV will begin to decline for the first time since HIV was identified in the early 1980s.[1]

By 2020: Reduce new HIV infections (incidence) to no more than 23,000 per year.
By meeting all of the goals as outlined in the *Updated National HIV/AIDS Strategy for 2015-2020*, we can reduce the number of new HIV infections per year to 23,000 or less. The Updated NHAS employs a "90-90-80" framework meaning 90% of persons living with HIV are diagnosed, 90% access quality HIV care, and 80% of persons in care achieve viral suppression. If service targets sufficient to meet this 90-90-80 strategy are met (along with the necessary concomitant diagnostic, prevention, housing and supportive complementary care services), then 23,000 or fewer HIV infections is a reasonable goal for 2020. However, scaling up services sufficiently to meet the 90-90-80 framework is critical, as is scaling up the other, related services noted above.

By 2025: No more than 12,000 HIV infections per year in the U.S.
We must set more ambitious goals for an NHAS from 2021 through 2025, targeting by 2025 that 95% of persons living with HIV in the U.S. will be diagnosed, that 95% of persons diagnosed will be retained in high quality medical care, and that 95% of persons in care will achieve viral suppression. With such a 95-95-95 framework and the set of comprehensive services outlined above in place, and with sufficient intensity of prevention and care efforts focused on communities hardest hit by the epidemic, we believe an appropriate HIV incidence goal is 12,000 or fewer new HIV infections by 2025.

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[1] These incidence goals are based on modeling performed by Dr. David Holtgrave, who is Chair of the Department of Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health. *See*: http://www.huffingtonpost.com/david-holtgrave/shaping-the-next-administrations-response-to-hiv-in-the-us_b_9826962.html?utm_hp_ref=healthy-living

Reduce HIV-related health disparities in the United States.

Sadly, HIV-related disparities across communities continue to persist in the U.S., driven by discrimination, stigma, and social and economic marginalization. In 2014 African Americans represented 13 percent of the U.S. population but accounted for almost half of new infections (49 percent) and 43 percent of people living with HIV;[2] MSM accounted for two-thirds (66%) of new infections in 2014, and the number of new infections among the youngest MSM (aged 13-24) increased 22% percent from 2008 to 2010;[3] an overall HIV infection rate of 28% has been documented in the transgender community;[4]; and the Southern states account for half of all AIDS diagnoses and deaths of HIV-positive persons in the U.S.[5]

Therefore, it is important that for all of the suggested goals noted above, they be achieved not only in absolute terms but also in a manner that reduces all such disparities. To achieve this goal of social justice will require a substantial intensification of service provision and commitment to a high quality care for gay men (in particular young Black and Latino men), Black and Latino/Latina communities, and persons residing in key urban areas as well as across the Southern U.S. The numeric goals listed above are important; achieving them in a socially just manner is just as critical and will require a focusing of efforts on communities now bearing the largest burden of the epidemic.

Develop a concrete strategy to end HIV as an epidemic by 2025.

Appoint a high-level expert and stakeholder task force to develop a detailed national plan to end the U.S. epidemic. We envision this Ending the Epidemic Task Force to be a temporary, action oriented body, inclusive of HIV treatment and prevention experts and stakeholders, including representatives of networks of people living with HIV. This body may include members of the Presidential Advisory Council on HIV/AIDS (PACHA), which is a permanent advisory body, but will be charged with the discrete task of developing a comprehensive blueprint for recommended federal actions and new and realigned financial commitments that build upon the current National HIV/AIDS Strategy to achieve the 2020 and 2025 goals for ending AIDS. The Task Force should report back to the new Administration on a timeline that enables the new President to adopt a concrete strategy for ending the epidemic as a key Year One priority.

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[2] CDC. *HIV Surveillance Report, 2014*; vol. 26. http://www.cdc.gov/hiv/library/reports/surveillance/ Published November 2015.
[3] CDC. Estimated HIV incidence in the United States, 2007– 2010. *HIV Surveillance Supplemental Report* 2012; 17(No. 4).
http://www.cdc.gov/hiv/topics/surveillance/resources/reports/#supplemental. Published December 2012.
[4] Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav* 2008;12(1):1-17.
[5] CDC. *HIV and AIDS in the United States by Geographic Distribution*.
http://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html Updated May 2015.

Commit to the following interrelated activities to end HIV in the United States.

To achieve all of the NHAS goals, establish a 95-95-95 framework by 2025 and address HIV health disparities so that no community or population in the U.S. is left behind, the next President must commit to a strategy that includes the following interrelated priorities.

Adopt 21st century surveillance strategies to know the U.S. epidemic.
It is critical to understand who is living with HIV and make sure they are getting needed services, to know where HIV is being transmitted in order to intervene quickly to prevent transmission, and to disaggregate HIV transmission, incidence, and prevalence data by demographic, risk group, and geographic area in order to rationally target interventions and resources, without jeopardizing privacy and human rights.

- Modernize our national HIV surveillance system. We now have key metrics that lag three to six years behind (CDC's most recent estimate of HIV incidence is for the year 2010) and data that fails to accurately reflect some groups such as people of trans experience. This impedes the national ability to mount a nimble response to the epidemic and rapidly make real time adjustments. We must reinvest in our national HIV surveillance system, including support to improve both CDC and state data systems.
- Develop a transparent, real time, publicly-available dashboard of epidemiologic, service delivery, and programmatic impact information that can be used to gauge annual progress toward NHAS and other HIV-related goals.
- Develop and implement indicators to measure both the impact and effect of HIV related stigma. The US Stigma Index formulated by the Global Network of People with AIDS (GNP+) is part of a global effort to identify the root causes of stigma taking into account geographical differences and population needs.

Reduce new HIV infections through evidence-based combination prevention for both HIV-negative and HIV-positive persons.

While we work to diagnose and treat all Americans with HIV and AIDS, we also must work to prevent exposure. Biomedical, behavioral and structural interventions used together are needed to significantly reduce HIV transmission. Routine and voluntary universal HIV testing is a gateway to HIV prevention for those who test negative; effective treatment for HIV-positive persons decreases viral load and reduces the potential for transmission; and both groups benefit from interventions to address behavioral and structural factors that increase the risk of acquiring and transmitting HIV.

HIV prevention services must be comprehensive and include:

- High quality, age appropriate HIV, reproductive and sexual health education at all levels.

- Routine screening for HIV for all persons over age 15 as preventive care.
- Access to pre-exposure prophylaxis (PrEP) for those who need it.
- Wide access to non-occupational and occupational post-exposure prophylaxis (PEP).
- Syringe access and other harm reduction services as needed by HIV-positive persons and HIV-negative persons.
- Coverage of HIV prevention, including PEP, PrEP, and treatment as prevention [TasP] as essential services under the Affordable Care Act (ACA) prevention mandate.

Both the CDC and the World Health Organization recommend widespread use of PrEP among members of at-risk groups. In March 2015, the CDC allocated $125 million over three years in grants to state and local health departments to increase knowledge about and uptake of PrEP among transgender individuals and Black men who have sex with men (MSM). The CDC investment must be expanded to ensure populations at greatest risk of infection have access to PrEP medications, health services and adherence supports, and to encourage and fund states to support combination prevention.

Effective HIV prevention for young MSM and transgender persons will also require efforts to combat youth homelessness. LGBTQ youth are vastly overrepresented in the homeless population: up to 45 percent of homeless youth identify as LGBTQ, even though LGBTQ youth comprise just 5 to 7 percent of the overall youth population.

<u>Maximize the number and proportion of people able to suppress HIV viral load as rapidly as possible following an HIV diagnosis.</u>

Federal guidelines now recommend routine screening for all persons 15-65 in the United States, and antiretroviral treatment for all adults and adolescents diagnosed with HIV. Treating HIV as soon as possible following infection promotes optimal health, reduces HIV-related death and virtually eliminates ongoing HIV transmission.

Ensuring effective, high-quality HIV care that leaves no one behind will require:

- Secure, affordable and high quality testing and treatment for all people with and at risk of HIV. The next President must use the power of the Centers for Medicare and Medicaid Services (CMS) to induce all states to buy into Medicaid expansion under the Affordable Care Act to provide life-saving HIV prevention, testing and health care to people in every region of the U.S.; and equalize Medicaid for Puerto Rico and other U.S. territories. An analysis of the ACA's impact on persons living with HIV estimated that of 70,000 persons with HIV who were uninsured before the law, roughly 47,000 would be newly eligible for Medicaid. However, with the Supreme Court's ACA decision, these new eligibility criteria only apply in states that accept Medicaid expansion. As a result, childless low-income Americans in non-

expansion states remain ineligible for Medicaid if they contract HIV and remain asymptomatic. To end AIDS, every state must extend Medicaid coverage to provide life-saving HIV prevention and health care.

- A cap on out-of pocket expenses for people with HIV/AIDS. Ensuring that Americans can get the care their doctors prescribe requires that health insurance plans cap covered out-of-pocket prescription drug costs at $250.
- Maintaining and expanding the highly successful Ryan White HIV/AIDS program to provide HIV prevention and care services for those who do not have sufficient health care coverage and those who require services to support effective HIV treatment.
- Directing the Secretary of Health and Human Services to negotiate lower drug prices, reduce barriers to the importation of lower cost drugs from other countries and stop direct-to-consumer advertising subsidies for drug companies—reinvesting those funds in research.
- Adequate funding for mental health and substance use services for people living with and at risk for HIV, including assurances of coverage parity of these services by all payers.
- Attention to the complex treatment issues presented by the "greying" of the U.S. HIV epidemic, with over half of people living with HIV in the U.S. now over age 50, to improve care for older adults dealing with both HIV and aging who face the challenges that include co-morbidities and resulting polypharmacy issues, access to appropriate housing and supports, and mental health issues such as depression, loneliness and AIDS survivors' syndrome.
- Comprehensive responses that are responsive and proportional to the severity of HIV health disparities.

<u>Assure availability of essential services that support health, prevention, and retention in care</u>**.**

ACA and Medicaid expansion alone will not assure that all people and communities living with or at risk of HIV are able to stay healthy and avoid contracting or transmitting HIV. For HIV-positive persons, retention in care requires culturally competent services to address a cluster of health, behavioral and structural issues. Poverty, unemployment and underemployment drive the U.S. HIV epidemic, and homelessness, hunger and other unmet subsistence needs are powerful barriers to effective HIV care and treatment.

Eliminating new HIV infections and retaining persons with HIV in successful treatment will require:

- Continued and expanded support of federal initiatives to address homelessness and housing insecurity among people with HIV, including the Housing Opportunities for People with AIDS (HOPWA) program.
- Expanded federal supports for job training and employment opportunities for people with HIV.

- Federal policies that support efforts to address hunger and to meet transportation and other basic subsistence needs – supports that are crucial to engaging and keeping vulnerable persons in care.
- Addressing other structural contributors to the U.S. HIV epidemic, such as the criminalization of nonviolent drug violations and adult consensual sex work, interpersonal violence, the burden of disproportionate incarceration and entanglement with the criminal justice system for young men of color and transgender persons, and barriers to prevention and care services for new immigrants including the African Diaspora community.
- Federal leadership to end HIV criminalization – the inappropriate use of one's HIV positive status in a criminal prosecution – by eliminating HIV-specific laws that are outdated, do not reflect current scientific understanding and are at odds with public health strategies.

<u>Provide, support, and sustain high-level political and community leadership</u>**.**

A successful plan to end AIDS as an epidemic will require strong leadership from the new President, a revitalized and fully-funded Office of National AIDS Policy (ONAP) with the authority to direct interagency action and ensure accountability, and a renewed Presidential Advisory Council on HIV/AIDS (PACHA) with the expertise required to advise the Administration and oversee the U.S. plan to end to end AIDS. It is particularly critical to select an ONAP director who has the knowledge and authority to direct a strategy to end AIDS and who is responsive to the community.

We ask that this commitment begin with appointment of an HIV advisor for the next President's campaign and transition team with the mission, purpose and authority to work towards a concrete plan to end of the U.S. epidemic by 2025. We would expect this advisor to reach out to members of the HIV community in all parts of the U.S. and its territories during the course of the campaign and to ensure the meaningful involvement of networks of people living with HIV as well as other community leaders in the selection of administration officials charged with the development and implementation of the strategy to end AIDS domestically and globally.

<u>Make the smart, strategic investments necessary to end the HIV epidemic</u>.

Ending AIDS in the U.S. will also require a sustained and more strategic investment of public funding – starting with a review of all federal HIV investments in order to redirect funding to effective interventions and high-burden communities and populations. An effective plan will also require new investment of resources. But we believe that the right investments now will not only produce better individual and public health outcomes but also reduce overall costs.

The NHAS did not contain estimates of the costs necessary to scale up the recommended HIV prevention, care and housing services, and since the release of the NHAS in 2010 there have been only marginal increases in federal support of HIV services – well below what has been estimated as necessary to achieve full-scale implementation of the NHAS.

Much of the necessary additional investment would be covered under the Affordable Care Act if all states expand Medicaid services. The rest could come from discretionary programs that are newly funded or that receive redirected funding support. Moreover, investments now to significantly reduce new HIV infections will save both lives and money, generating savings more than sufficient to fund a comprehensive strategy to end the U.S. epidemic.

While an estimate of the type and amount of new investments required is beyond the scope of this policy paper, we can provide a threshold analysis of the level of investment that would constitute a cost-effective use of public resources.[6] The present value of medical costs saved by avoiding one HIV infection has been very conservatively estimated at $229,800 to $326,500, with the costs per infection higher if HIV-infected individuals present early and remain in care.[7]

CDC's most recent incidence estimate for 2010 is 47,500 new HIV infections per year. If we compare a stagnant 47,500 new infections per year with accelerated annual reductions to reach the 2020 and 2025 incidence targets described above, that translates into over 257,500 averted HIV infections between 2016 and 2025, for a savings of $59 billion to $84 billion in avoided health spending (where each HIV infection averted saves $229,800 to $326,500 in discounted lifetime medical care costs). Applying the accepted assumption that roughly three-quarters of HIV medical costs are publicly funded, this translates into between $44 billion and $63 billion in public spending for future HIV treatment that could be better used between now and 2025 to fund the care and services needed to prevent these new infections and stop AIDS deaths to make history by ending the U.S. epidemic, *and the investment still be considered cost-saving*.

Support ending the global AIDS pandemic by 2030

We urge the next President to support the global plan to end AIDS by the year 2030 by acting to: double the number of people directly supported by the U.S. on life-saving HIV medicine by 2020 as part of leading a worldwide effort to meet the global target of treatment for over 30 million people by 2020 and to increase U.S. HIV treatment access to over 95% of the total HIV-positive population; cut HIV infection among young women and girls; expand initiatives to address the social and

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[6] This cost-effectiveness analysis is based on modeling performed by Dr. David Holtgrave.

[7] Schackman BR, et al. The lifetime medical cost savings from preventing HIV in the United States. *Med Care* 2015; 53(4): 293-301. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

economic drivers of HIV, poverty, and inequality; and support rights-based responses to address the needs of marginalized populations, including MSM, transgender persons, people who use drugs, sex workers, prisoners, immigrants, migrants, displaced and homeless persons.

UNAIDS has found that reaching "90-90-90" by 2020 and 95-95-95 by 2030 is the key to ending the global AIDS crisis (90% of people living with HIV know their status, 90% of those diagnosed are on treatment, and 90% of those on treatment are successfully "virally suppressed"). The U.S. has expressed support for the global 90-90-90 targets, which will require more than doubling the number of people with HIV on effective treatment worldwide over the next four years.

Increase and sustain U.S. global AIDS funding.

The President's Emergency Plan for AIDS Relief (PEPFAR) has made critical investments in countries to end the AIDS crisis and requires at least an additional $2 billion in funding per year by 2020. This funding would allow the U.S. to do its fair share toward ending global AIDS—covering one-third of the current global AIDS financing gap. At the end of fiscal year 2015 U.S. funding directly supported 5.7 million people on HIV treatment through PEPFAR and many more through the Global Fund. By 2020 the U.S. can double this number to directly reach at least 11.4 million people with lifesaving services, a significant contribution toward reaching 30 million in the world as a whole that year. Two billion dollars ($2 billion) reflects the cost of this doubling (at PEPFAR's cost of roughly $200 per patient), which would help eliminate mother-to-child HIV transmission while also expanding funding to reduce new HIV infections in young women and girls and to end tuberculosis as the number one killer of people living with HIV in Africa. We ask the next President to pledge to fund an annual $500 million increase for each of the next four years for bilateral (PEPFAR) AIDS programs to reach a $2 billion increase by 2020.

In addition, the Global Fund to Fight AIDS, TB and Malaria is the essential multilateral funding mechanism through which U.S. funding is matched 2 to 1 by other donors. The next President should call for exceeding the current Global Fund replenishment target and commit to contribute one-third of the financing.

Ensure adequate HIV prevention and care in middle-income countries.

There has been a trend recently toward donors pulling AIDS funding out of middle-income countries, assuming these countries can afford to take care of their own epidemics. The U.S. should use diplomatic leverage to ensure that middle-income countries continue and grow their treatment and prevention programs while recognizing that U.S. assistance may still be needed to fund programs for critical civil society work that governments won't fund and for programs addressing the needs of LGBTQ persons, sex workers, women and girls, and people who use drugs.

Leverage other national and international resources to address the social and structural drivers of the epidemic.

To end AIDS globally and in the U.S., we must also act to address the social and structural drivers of vulnerability and poor health outcomes. It is well-understood that social deprivation and marginalization are key drivers of the HIV epidemic – including poverty, gender inequity, inequality and exclusion, mental health distress, stigma, criminalization, housing and food insecurity and interpersonal violence – and that the impacts of HIV responses depend on multi-sectoral investments that target these barriers to effective prevention and care. Comprehensive, rights-based responses are particularly critical for members of disparately impacted key populations experiencing substantial human rights violations and barriers to accessing services.

In order to address the crisis of HIV among young women, MSM, sex workers, people who use drugs and other socially and economically marginalized persons with and at risk of HIV, we ask that the next President pledge a new $1 billion funding initiative per year by 2020 specifically to address the social and structural drivers of HIV infection and poor health outcomes.

It is also critical to leverage broader cross-sector initiatives and resources to address key drivers of HIV. Available evidence demonstrates the effectiveness of a range of approaches in simultaneously strengthening HIV prevention and treatment while bolstering development and human rights aims – from economic empowerment, to social protection programs, to transformative approaches such as decriminalization, anti-discrimination laws and campaigns to change social norms. We call on the next President to actively support integrated, intersectoral strategies to address the social, structural and political drivers of poverty, inequalities and HIV, including actions to eliminate poverty and inequalities, provide access to comprehensive social protection and child protection, improve food security, stable housing and access to quality education and economic opportunity, achieve gender equality, reduce the harm associated with drug use and sex work, and promote healthy cities and just and inclusive societies.

Seek innovative strategies to expand available resources.

Critical funding could come from innovative sources and we urge the candidates to champion solutions such a Financial Transaction Tax (FTT) to provide billions in new revenue to help fund biomedical research and development and HIV/AIDS programming.

Maintain U.S. leadership in lifesaving research

We are living at a time of unprecedented promise in U.S. biomedical research. To fulfill that promise requires stable, substantial, sustained multi-year increases for biomedical research overall by the U.S. National Institutes of Health (NIH) as well as corresponding increases for the NIH HIV/AIDS research program carried out by the institutes and coordinated by the Office of AIDS Research (OAR). We ask that the next President commit to supporting annual budget increases for the NIH of 10-15% per annum for eight years, and for corresponding increases in the NIH AIDS research budget, taking into account the significant scientific opportunities and unmet needs posed by the search for a vaccine, a cure, better treatments, and implementation science on health service delivery models to end the epidemic in the U.S. by 2025 and globally by 2030.

Ensure affordable access to medicines for all

The extraordinary expansion of HIV/AIDS treatment globally – to over 16 million people – has been possible only because of the absence or elimination of intellectual property barriers, allowing robust generic competition resulting in a 99% drop in the price of drugs. However, the global ratcheting up of intellectual property rights on medicines via the World Trade Organization (WHO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and ever increasing demands that go far beyond TRIPS in trade and investment agreements is threatening AIDS treatment goals. It is critical for the next President to support trade and other policies that reduce intellectual property barriers to medicines rather than raise them.

In particular, we ask the next President to pledge to stop the Trans-Pacific Partnership, U.S. pressure on India (the pharmacy of the poor), and trade threats under the Special 301 Watch List. Developing countries should be allowed – indeed encouraged – to use all lawful TRIPS public health flexibilities to encourage generic competition and expanded access to affordable medicines. The next President should go even further in exploring the potential of new, globally coordinated incentive systems for prioritized medical research and development – grants, prizes, and other incentives – strategies known as delinkage. In particular, the next President should pledge that all publicly financed research will be governed by a non-exclusive license that allows generic competition for affordable access at home and abroad to the fruits of science funded by taxpayers. The next President should also urgently address the price gouging of the biopharmaceutical industry within the U.S., where, for example, excessive pricing is leading to rationing medications to cure hepatitis C, a leading cause of death for people with HIV.

Support the role of civil society globally and in the U.S.

We ask the next Administration to commit as well to leverage national and international and international support for civil society organizations and networks that engage in advocacy and other activities on behalf of people living with ad at risk of HIV/AIDS, and, where US funds are involved, domestically and internationally, require that people living with HIV who are representative of the epidemic are included in decision-making, implementation, and evaluation processes.

Learn more from members of HIV communities across the U.S.

Finally, we urge each Presidential candidate to continue to reach out and meet with all of the varied U.S. communities living with and affected by HIV. While HIV/AIDS is a critical issue for the LGBTQ community, it touches a wide range of Americans and each state and local HIV epidemic is unique.

We hope that this meeting is a first step and have urged HIV communities around the country to reach out to the campaigns and invite the candidates to visit with them in their communities and hear their stories. We hope the following list of contacts will facilitate those connections.

Jose Abrigo
HGBTQ/HIV Advocacy Project

William E. Arnold
Community Access National Network (CANN), USA

John Barry
Southern Tier AIDS Program, NY

Merith Basey
Universities Allied for Essential Medicine (UAEM), USA

Benjamin Bashein
ACRIA, NY

Nancy Bernstine
National AIDS Housing Coalition, USA

James Bolas
Coalition for Homeless Youth, NY

Rebecca Botting
Activist, NY

Guillermo Chacon
Latino Commission on AIDS, Hispanic Health Network, USA

Cecilia Chung
US People Living with HIV Caucus, USA

William Scott Daly
Activist, NY

JD Davids
thebody.com, USA

Jose Davila
BOOM! Health, NY

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Sharen Duke
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Jim Eigo & Andy Velez
ACT UP New York, NY

William Faragon
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Sergio Farfan
Louisiana Latino Health Coalition for HIV/AIDS, LA

C. Virginia Fields
National Black Leadership Commission on AIDS, USA

Kevin Fisher
AVAC: Global Advocacy for HIV Prevention, USA

Ingrid Floyd
Iris House, NY

Miasha Forbes
Just for Us, USA

Latisha Gibbs
Health People, NY

Mark Harrington
Treatment Action Group, USA

Deon Haywood
Women with a Vision, LA

Kathie Hiers
AIDS Alabama, AL

Ernest C. Hopkins
San Francisco AIDS Foundation, USA

Brian Hujdich
Pozitively Health Coalition, USA

Carine Jocelyn
Diaspora Community Services, NY

Marsha Jones
Afiya Center, TX

Howard Josepher
Exponents, NY

Perry Junjulas
Albany Damien Center, NY

Paul Kawata
NMAC, USA

Nainna Khanna
Positive Women's Network, USA

Jacquelyn Kilmer
Harlem United, NY

Charles King
Housing Works, NY

Thomas Krever
Hetrick-Martin Institute, NY

Andrea Levario
Human Rights Campaign, USA

Kelsey Louie
Gay Men's Health Crisis
(GMHC), NY

Alan Timothy Lunceford-Stevens
End AIDS Now, NY

Brandon M. Macsata
ADAP Advocacy Association (aaa+), USA

Suraj Madoori
HIV Prevention Justice Alliance, USA

Carolyn McAllaster
Southern HIV/AIDS Strategy Initiative, SC

Demetrius McCord
Harm Reduction Coalition, USA

Brian McIndoe
William F. Ryan Community Health
Network, NY

Matthew McMorrow
Lambda Independent Democrats of
Brooklyn, NY

Hilary McQuie
Health GAP, USA

Judith Montenero
Latinos in the Deep South, USA

Rev. Moonhawk
Empire State Pride Agenda, NY

David Ernesto Munar
Howard Brown Health, IL

William Murphy
Chelsea-Clinton Community
Health Center, NY

Kim Nichols
African Services Committee, NY

Kathy O'Brien
Hyacinth AIDS Foundation, NJ

Morolake Odetoyinbo
Positive Action for Treatment Access (PATA), Nigeria

John Peller
AIDS Foundation of Chicago, IL

Chuck Peterson
Clare Housing, MN

Regina Quattrochi
Bailey House, NY

Michael Emanuel Rajner
Florida Activist, FL

Kyle Rapinon
Sylvia Rivera Law Project, NY

Elana Redfield
New York Community Activist, NY

Victor Rivera
Bronx Parent Housing Network, NY

Therese Rodriguez
Apicha Community Health Center, NY

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