HIV + HEP
POLICY INSTITUTE

To Inform the Development of the 2026-2030 National HIV/AIDS Strategy and the National Strategic Plans for Sexually Transmitted Infections, Vaccines, and Viral Hepatitis

Addressing Syndemics

Many of the infectious diseases included in these strategies are sexually transmitted; therefore, age-appropriate sexual education, which includes positive attitudes towards different sexual orientations, must be included. Negative messages against certain sexual orientations, which lead to stigma and disengagement from medical care, must be called out and stopped. In order to address sexual education, there needs to be funding of these programs, both at the state and federal levels, as well as proper curriculum. This must include the Department of Education and parts of the CDC. Funding and policies that are not based on science must not proceed.

Addressing these infectious diseases also takes public education, testing and linkage to care and treatment. Addressing each of them together is cost-effective. Therefore, when policies and programs are formulated and funded, the syndemic approach must be considered.

Organizational Use

As a policy and advocacy organization we work to ensure there are the proper policies, programs, and funding to implement the Strategic Plans. We also refer to them in our work with the Congress, media, and the public to help educate them on the strategic plans and national goals included in each of the plans. We use them to measure our progress in meeting the goals. We not only use them to advocate before the Congress but also within government agencies and leadership to hold them accountable to ensure the goals are reached and that proper policies and programs are in place with sufficient funding.

The strategic plans must be attainable and the policies, programs and the funding must be detailed to educate the public and policymakers about what is truly needed to attain them.

Communicating Progress

Annual progress reports should continue which demonstrate how we are doing in reaching the goals and also the activities each agency is doing. The dashboards and state profiles are also important.

There needs to be a better job of reporting progress by each state and call out of jurisdictions that are not doing a good job in meeting their goals.

NHAS Priorities

The overall strategy, including its vision, targets, activities and priority populations are, for the most part, still current and should be maintained. Knowledge of one's status, linkage to and maintenance to care and treatment to achieve viral suppression, addressing disparities, increasing prevention, including PrEP, and working in a syndemic, whole of society and government approach all are necessary to end HIV.

HIV + HEPATITIS POLICY INSTITUTE
1602B Belmont Street NW | Washington DC 20009 | 202-462-3042 | 202-365-7725 (cell)
HIVHep.org | Twitter: @HIVHep | Facebook: HIVHep

Since we have or soon will reach the PrEP uptake goal of 50 percent, that indicator should be increased to 75 or 80 percent.

In terms of priority populations, since there has been progress with youth, perhaps that population can be modified to the ages that are most impacted by HIV today.

Resources should be allocated and directed to the populations most impacted by HIV. No population should be left behind, including Black, Latino and White gay men, and efforts to eliminate disparities should continue.

More people, including those living with or vulnerable to HIV, particularly since the passage of the ACA, have some form of health coverage, including Medicaid, Medicare, or private insurance. These programs are governed by CMS, which should be a more central player in the strategy and its implementation. Related to this, the strategy should include activities associated with overcoming barriers to prescription drug access, no matter the payer. Insurers are placing more barriers to access and using discriminatory plan designs, not covering certain drugs used to treat or prevent HIV or imposing cumbersome access barriers like prior authorization. More vigorous enforcement by insurance regulators is needed, including the rules regarding no-cost access to PrEP drugs, labs, and visits.

If we are to end HIV, the funding of domestic HIV programs should be more equitably distributed, which means that it should be based on need. This will help communities in the South, particularly in those states that have not expanded Medicaid.

States should be held more accountable for their results. They should be published and scored as to how well they are doing. If states are not performing, more funding should be directly distributed to community-based organizations in the state.

Some issues that impact HIV, such as homelessness, cannot be solved with HIV funding. While the need is great and the overall resources are limited, the strategy must recognize that there are other federal housing programs and strategies that the HIV programs can work with and leverage for people living with HIV.

While the current Strategy addresses the private sector role, this is one area that should be strengthened. The resources of the federal government and the advocacy of the HIV community can be amplified with the assistance of the private sector in so many areas, including in reducing HIV stigma.

The funding needed to accomplish the goals of the strategy along with its proposed activities should be included.

STI Plan Priorities

We would prioritize HIV testing and access to PrEP in STD clinics. They are perfect settings to conduct these activities.

Viral Hepatitis Plan Priorities

The overall strategy, including its vision, targets, activities, and priority populations are, for the most part, still current and should be maintained. Preventing new hepatitis infections, improving health outcomes, reducing disparities, improving surveillance and data usage, along with an integrated coordinated effort all are necessary to end hepatitis.

We believe that there should be a greater focus on two areas: testing in general and curing hepatitis C. While they are both mentioned, since those who are aware of their hepatitis status is low, especially compared to HIV, the strategy should focus on testing. Perhaps instead of highlighting surveillance and data, in its place there should be an overall goal to increase knowledge of hepatitis status, with the surveillance and data issues listed as subgoals.

Instead of a subgoal to improve health outcomes for people living with hepatitis C, we believe that should be renamed to focus on increasing the number of people who have been cured of hepatitis C.

We continue to support all the other activities, including increasing vaccine uptake and finding a cure for hepatitis B.

Since people living with hepatitis B and C are facing access barriers of their prescription drugs by payers, including Medicaid and private insurance, CMS should be more involved in the strategic plan's implementation.

Since hepatitis activities are severely underfunded, we believe the federal government should detail the amount of funding that is needed to attain the goals.

In order to create a greater focus on hepatitis and the opportunities to eradicate it, there should be an opportunity for the private sector to be involved in the strategy and its implementation.

Additionally, there should be a federal advisory council focused on hepatitis.

As hepatitis programs receive little funding, the strategy and its implementation activities must utilize the syndemic approach and rely on health systems already in place, such as community health centers and the Ryan White Program for those who are dually infected.