

A New HIV Prevention Paradigm for Gay and Bisexual Men in the U.S.

The National HIV/AIDS Strategy calls for renewed efforts to reduce HIV infection rates, increase access to lifesaving care, and reduce the health disparities that characterize the U.S. epidemic. Achieving these aims will require substantially greater progress in preventing new HIV infections among gay and bisexual men, who account for the majority of people living with HIV in the U.S.

Available evidence indicates that traditional risk reduction strategies on their own are inadequate to turn the tide against AIDS. This underscores the need for new approaches to address the broader social and structural factors that

contribute to disproportionate infection rates among gay and bisexual men.* This issue brief outlines a new paradigm for HIV prevention in the gay community.

The Epidemic's Impact Among Gay and Bisexual Men

Since the disease was first recognized in 1981, AIDS has claimed the lives of more than 300,000 gay and bisexual men in the U.S.¹ Gay and bisexual men[†] account for 53.1 percent of the country's estimated 1.1 million people living with HIV² and for 57 percent of all new HIV infections.³ One modeling

Key Points

Gay and bisexual men have been **more heavily affected by HIV/AIDS** than any other population in the U.S.; more than 300,000 have lost their lives since the epidemic began. They account for 57 percent of new HIV infections, and the annual number of new infections in this population has increased steadily over the last two decades. One modeling exercise has suggested that, in the absence of new interventions, a gay man who is 18 years old today faces a two in five chance of becoming infected with HIV by the time he is 40.

A **new approach** is needed to reduce the HIV infection rate among gay and bisexual men in the U.S. To date, prevention efforts have largely aimed to promote safer sexual behaviors. But although behavioral interventions are critical to successful prevention efforts, by themselves they are unlikely to reverse the epidemic among gay men.

Antiretroviral therapy (ART) has saved thousands of lives and also helps prevent new HIV infections. To maximize the **prevention potential of treatment**, efforts are needed to increase timely knowledge of HIV serostatus, link people

who test HIV-positive to quality medical care, and enhance treatment adherence.

Anti-gay stigma and discrimination increase gay men's vulnerability to HIV in numerous ways. Legal reform and policy changes are needed to implement anti-discrimination laws, enforce anti-bullying provisions in schools, and sensitize healthcare workers to lesbian, gay, bisexual, and transgender (LGBT) issues.

Greater investment is needed in community-level strategies that **forge healthy social norms** and function as an ongoing "social vaccine."

Immediate steps are needed to reverse the historic **under-prioritization of prevention services for gay and bisexual men** within the broader HIV prevention effort, and to **bring effective interventions to scale** where they will demonstrate population level impacts.

Pre-exposure prophylaxis (PrEP) is a new and potentially promising prevention intervention that needs additional study.

* The policy recommendations in this issue brief are primarily drawn from the results of an expert consultation convened in October 2010 by amfAR, The Foundation for AIDS Research, and Trust for America's Health. The consultation was supported with funding from the M•A•C AIDS Fund.

† Epidemiological statistics cited for gay and bisexual men include such men who also inject drugs.

exercise has suggested that a gay man who is 18 years old today faces a two in five chance of becoming infected with HIV by the time he is 40.⁴ Because gay and bisexual men comprise the majority of HIV infections in the U.S. and are the only risk group among which new HIV cases are increasing, improving the HIV response domestically will require devising more effective strategies aimed at this population.

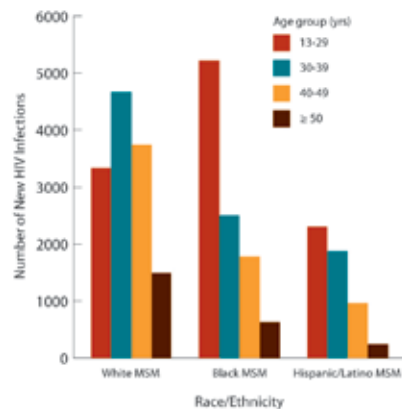
Although gay communities were responsible in the 1980s and early 1990s for some of the greatest HIV prevention successes, these gains have not been sustained. The annual number of new infections among gay and bisexual men has increased steadily over the last 20 years, possibly by as much as 50 percent.³

Although white men represent the largest number of new HIV infections among gay and bisexual men (46 percent), men from other racial and ethnic groups are more likely to become infected. In 2006, African-American gay and bisexual men were more than seven times more likely than whites to become infected, and Latino men more than twice as likely.⁵

Research sponsored by the Centers for Disease Control and Prevention (CDC) has long demonstrated that many young gay men are at high risk of HIV infection.⁶ Risks are especially pronounced for young gay African-American men, who are more likely to become infected at an early age than their white counterparts.⁵ In addition, the odds that a

gay or bisexual man will have HIV increase with age. Among participants in a recent 21-city CDC study, HIV prevalence ranged from seven percent among 18–19-year-olds to 28 percent among men in their forties.⁷

Estimated Number of New HIV Infections among Men Who Have Sex with Men (MSM), by Race/Ethnicity and Age Group, 2006



Source: CDC. Subpopulation Estimates from the HIV Incidence Surveillance System—United States, 2006. *MMWR*. 2008; 57(36):985–989.

Figure taken from HIV among Gay, Bisexual and Other Men Who Have Sex with Men (MSM), CDC, September 2010.

The Limits of Traditional HIV Prevention Strategies for Gay and Bisexual Men

Since CDC began supporting HIV prevention programs in the 1980s, these efforts have primarily focused on encouraging individuals—including gay and bisexual men—to avoid risky sexual behaviors.⁸ Few behavioral interventions have been validated for gay men, compared to other at-risk populations.⁹ Most validated behavioral interventions are targeted to individuals, with relatively few intended to operate at a community level.^{9,10} All of the behavior-change programs currently in use in the U.S. are based on a narrow spectrum of cognitive behavioral theories.^{11,12} In addition, most of the interventions validated for gay men were studied in largely white cohorts, with few programs specifically assessed to ascertain their impact among African-American or Latino men.¹³

According to observational data in several countries in which behavioral interventions have been implemented, reductions of HIV incidence or prevalence between 50 and 90 percent have been observed.¹⁴ Yet the failure of the U.S.

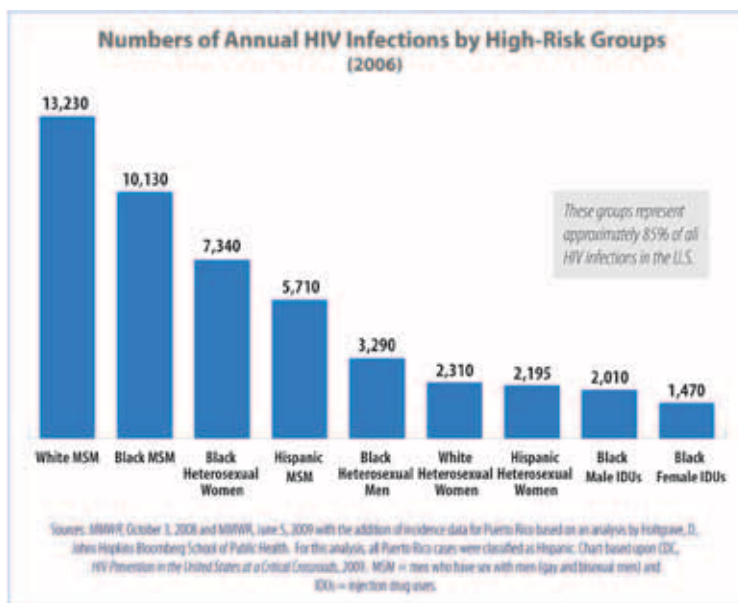


Figure taken from the National HIV/AIDS Strategy for the United States, 2010.

to achieve a meaningful reduction in the annual number of new HIV infections over the last two decades suggests that such approaches may have less public health impact than the professional literature indicates. Indeed, there are several reasons for concluding that individual-focused behavior change strategies should be only one element of a comprehensive approach to prevention among gay and bisexual men:

- *Results from controlled clinical trials are difficult to replicate in the real world.* It is often difficult for community organizations to deliver behavioral interventions exactly as prescribed in a clinical trial design. The characteristics of actual program participants frequently differ from those studied in the original trial. And many program participants drop out before completing the entire program or are exposed only to certain intervention components.

Few intervention studies follow participants longer than 12 months, raising questions about how long favorable behavior changes are actually sustained. Nearly all behavioral intervention trials rely on participants' self-reported sexual behaviors, which have been shown to be unreliable indicators of actual behavior.¹¹

- *When the risk of HIV exposure within a population is extremely high, incremental changes in sexual behavior are often insufficient to protect against infection.* Estimates of HIV prevalence within the broader population of gay and bisexual men in the U.S. range from 12 percent¹⁵ to 19 percent.⁷ In many urban settings, the percentage of gay and bisexual men who are living with HIV is considerably higher. According to a recent multi-city survey conducted by CDC, 38 percent of gay men surveyed in Baltimore in 2008 were HIV infected, with similarly high rates reported in New York City (29 percent), Miami (25 percent), and San Francisco (23 percent).⁷

Where background HIV prevalence is so high, even very low levels of risk behavior may carry unacceptably high risk of HIV infection.¹¹ In Southern Africa, where entire national populations confront transmission risks comparable to those reported for gay and bisexual men in the U.S., it is recognized that behavioral strategies alone are insufficient to lower the epidemic's toll.¹⁶

- *Personal risk taking is but one element in vulnerability to infection.* A meta-analysis of studies on gay African-American men in the U.S. found that these men did

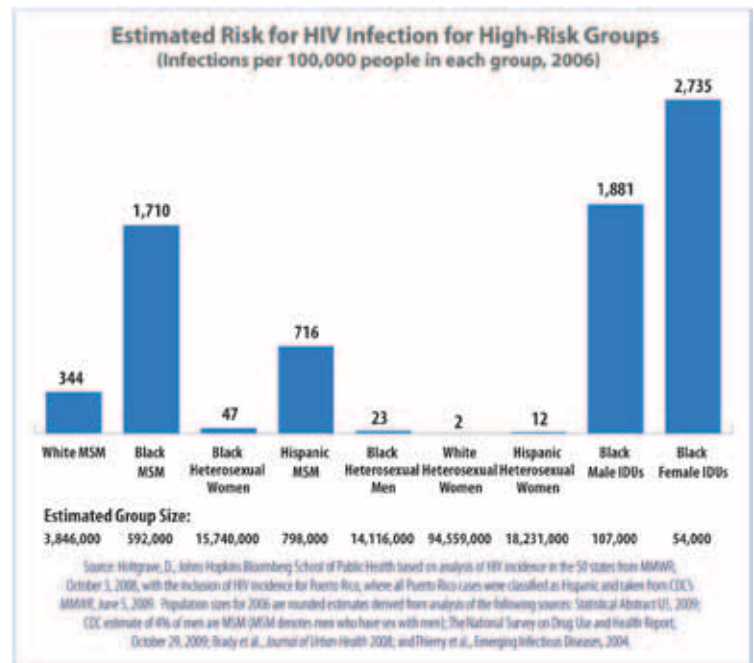


Figure taken from the National HIV/AIDS Strategy for the United States, 2010.

not practice riskier sexual behavior than their white counterparts, even though they have significantly higher HIV infection rates. The analysis found that gay African-American men are far likelier to have had higher rates of sexual risk early in the epidemic, untreated sexually transmitted diseases, undiagnosed HIV infection, and lower rates of antiretroviral therapy (ART) use.¹⁷

- *It is difficult to bring individual-focused behavioral interventions to scale.* The higher levels of virus circulating among men who have sex with men underscore the need to reach all gay and bisexual men with HIV prevention strategies. However, the behavioral interventions that constitute the largest share of CDC prevention programming (so-called “evidence-based interventions”) are extremely costly and labor-intensive and therefore difficult to bring to scale.* For example, Many Men, Many Voices, the most recent gay-focused behavioral intervention certified by CDC, involves six consecutive two- to three-hour sessions. Another CDC-validated intervention—Behavioral Intervention to Reduce AIDS Risk Activities—consists of 12 sessions of 75–90 minutes led by two clinical psychologists and two program assistants. The costs and participant commitments required for such intensive programmatic approaches inevitably limit their reach. According to a

* CDC-validated interventions for gay and bisexual men include Brief Group Counseling; EXPLORE; Many Men, Many Voices; and SUMIT. See <http://www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm>.

national survey of more than 10,000 gay and bisexual men, 15 percent report having been reached by an individual HIV prevention program during the preceding 12 months, with eight percent reached by group-level programs.¹⁸

- *Gay and bisexual men are consistently under-prioritized in the allocation of limited prevention resources.* Prevention programs are undervalued, accounting for a mere three percent of all federal AIDS spending.¹⁹ Within this limited U.S. commitment to HIV prevention, the needs of gay and bisexual men have been consistently under-prioritized.²⁰ According to CDC, for fiscal year 2009, only 41 percent of the agency's extramural budget for HIV prevention services was allocated for programs targeting gay and bisexual men (including those who also inject drugs),²¹ even though gay and bisexual men account for more than 50 percent of new infections each year and are the only risk group among whom new HIV cases are increasing.
- *Social and structural factors impede sexual risk reduction for many gay and bisexual men.* Behavioral interventions—which aim to equip individuals with the knowledge, motivation, and skills needed to reduce their HIV risk—presuppose that individuals have the means to take needed risk reduction steps. However, the freedom of choice for many gay and bisexual men is constrained by various social and structural factors. Explained in greater depth below, these factors include internalized homophobia, victimization by violence or sexual abuse, poverty, poor access to services, depression or other mental health disorders, and abuse of alcohol and/or drugs.

Addressing the Context of Risk: New Approaches to HIV Prevention

Efforts to encourage gay men to use condoms and have fewer sex partners will continue to be central to HIV prevention strategies. However, given the limits of such measures on their own to reduce the rate of new infections, behavioral strategies urgently need to be complemented by other approaches that extend beyond the individual and do not depend on individual action during each episode of sexual intercourse.

New ways of understanding the HIV/AIDS challenge in gay communities—ways that take into account community dynamics and the biology of HIV transmission—are critically needed. This section describes a new paradigm for HIV prevention that could complement and strengthen behavioral

strategies. It also includes general policy recommendations for implementing these measures. Specific recommended actions for federal, state, and local agencies are listed at the end of the brief.

Reducing HIV Transmission by Lowering Community Viral Load

Community viral load refers to the level of virus circulating within a neighborhood or social network, which has an important impact on the likelihood that a single episode of sexual behavior will result in HIV infection. Extensive epidemiological studies have strongly correlated the likelihood of HIV transmission with the infected partner's viral load.²²

By lowering viral load, ART has the potential to reduce rates of new HIV infections.²³ Cohort studies involving serodiscordant couples (i.e., couples in which one partner is infected and the other uninfected) have documented the prevention benefits of ART.^{24,25} A recent large-scale clinical trial among serodiscordant couples showed that starting ART early led to a 96 percent reduction in transmission to the HIV-negative partner.²⁶ Although nearly all (97 percent) of the couples in this study were heterosexual, the overwhelmingly favorable results indicate that this intervention may produce similar results among gay and bisexual men, though further study is needed.

The positive correlation between reduced community viral load and reduced HIV incidence has been observed in several population- or community-level studies. For example, in San Francisco, a 40 percent reduction in median viral load between 2002 and 2008 was associated with a 45 percent decline in the number of newly diagnosed cases of HIV.²⁷ One modeling study predicted significant reduction in HIV incidence in San Francisco with expanded antiretroviral treatment.²⁸

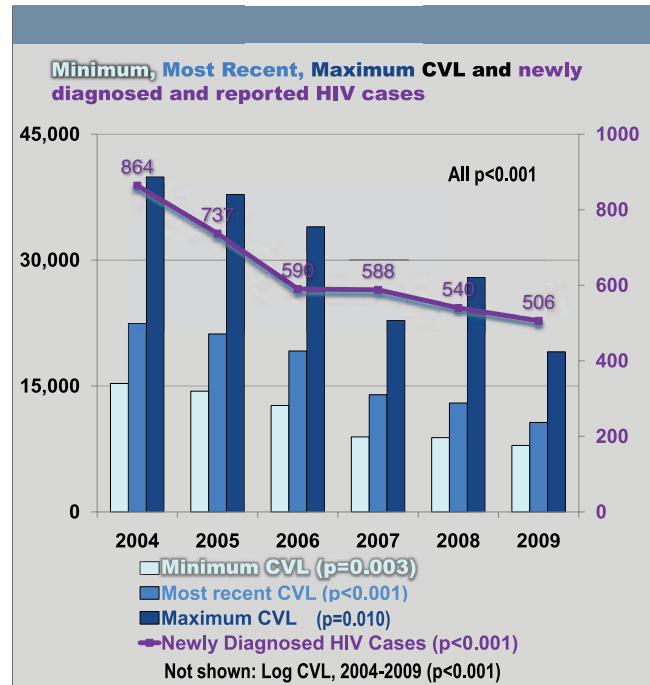
However, the prevention benefits of ART can only be realized under certain conditions. In particular, three steps are required:

- *Timely diagnosis of HIV infection.* CDC estimates that 21 percent of all people living with HIV remain undiagnosed.² In CDC's recent 21-city study of gay and bisexual men, 44 percent of those who tested HIV-positive during the study were previously unaware of their infection.⁷ African-American gay men are significantly more likely than their counterparts from other racial or ethnic groups to have

unrecognized HIV infection.²⁹ CDC researchers estimate that individuals with undiagnosed infection are several times more likely to transmit the virus than those who have tested HIV positive.³⁰

Experience demonstrates the feasibility of reducing rates of undiagnosed HIV infection. In San Francisco, for example, the percentage of gay and bisexual men with undiagnosed HIV infection fell from 23 percent in 2004 to 15 percent in 2008.²⁷ In particular, increasing the percentage of men with health coverage may well improve testing uptake, as CDC studies indicate that gay and bisexual men who lack health coverage are notably more likely to have undiagnosed infection than those with health insurance.⁷ Efforts should be made to increase providers' adherence to CDC recommendations for routine HIV screening in healthcare settings, as only about one-third (32.6 percent) of New York City internal medicine residents surveyed were aware of these recommendations.³¹ Policy solutions are also needed to remove various impediments to testing uptake, including onerous counseling and consent requirements, limited or nonexistent reimbursement for the full cost of testing services, and insufficient provider training.³²

- *Effective linkage to care for HIV-diagnosed individuals.* Federal officials estimate that 40 percent of HIV-diagnosed individuals are not receiving regular HIV primary care.³³ This is a problem common to all jurisdictions, including those with overwhelmingly gay epidemics. In San Francisco, 37 percent of people with diagnosed HIV infection are not in regular care, according to public health surveillance records.²⁷
- *Optimal viral suppression for HIV-positive individuals in care.* Efforts to reduce new infections may depend in large part on the quality and success of HIV treatment in lowering viral loads. Nationally, only about 55 percent of patients in HIV care experience full viral suppression (i.e., have viral loads of 500 copies/ml or less).³³ Episodic use of health services and suboptimal treatment adherence are the principal causes of inadequate viral suppression for people receiving HIV care.³⁴ According to a meta-analysis of available adherence studies, only 50 percent of patients on ART report at least 95 percent adherence to prescribed regimens, although studies demonstrate that adherence support interventions are able to significantly increase adherence rates.³⁵



Source: Das M et al. Success of Test and Treat in San Francisco? Reduced Time to Virologic Suppression, Decreased Community Viral Load, and Fewer New HIV Infections, 2004–2009. Conference on Retroviruses and Opportunistic Infections, Boston, 2011; Abstract No. 1022.

As a result of documented gaps in HIV diagnosis, linkage to care, and effective viral suppression, federal officials estimate that *only about one in four* (26 percent) HIV-positive persons are *both* in care *and* have sufficient viral suppression.³³

This represents an extraordinary missed opportunity. Annual HIV testing, combined with prompt initiation of ART, would prevent 20–28 percent of new HIV infections.³⁶ If combined with beneficial behavioral outcomes resulting from improved HIV testing and other prevention approaches, more effective use of testing and treatment could prevent nearly two-thirds (65 percent) of all new infections.³⁶ According to researchers, investments in testing and treatment services represent a highly cost-effective strategy to fight AIDS in the U.S.³⁶

Reducing Community Viral Load: Policy Recommendations

- *Enhance state and local HIV surveillance capacity to collect and analyze public health data pertinent to community viral load.*
- *Expand HIV testing, linkage to care, and adherence support through:*

- *New CDC investments, including public awareness campaigns and outreach about testing and care targeting gay and bisexual men and their clinicians;*
- *New investments and policy reforms by the Health Resources Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS);*
- *Changes to state testing policies to streamline consent and counseling requirements; and*
- *Changes to insurance reimbursement through state insurance reforms and implementation of the Affordable Care Act.*
- *Enhance healthcare access for gay and bisexual men through AIDS Drug Assistance Programs and the Affordable Care Act.*
- *Link prevention and treatment in service planning, using a unified service planning process and body to develop strategic and operational service plans, especially at the state and local levels. These plans should be driven by desired outcomes (e.g., reduced risk, reduced probability of transmission, reduced morbidity and mortality) rather than by service categories.*

Addressing Social and Structural Factors That Increase Risk and Vulnerability

Social and structural factors hinder the ability of many gay and bisexual men to reduce their sexual risk-taking. Due to stigma and discrimination, many gay and bisexual men avoid seeking HIV testing or prevention services. Many experience psychosocial problems that undermine their ability to adhere to safer sex practices. In the absence of concerted efforts to address these social determinants of risk and vulnerability, individual behavior change strategies are unlikely to be optimally effective.

At the broadest level, the most salient factor that impedes HIV prevention efforts is the enduring legacy of stigma and social disapproval associated with homosexual identity and behavior. It is well documented that gay and bisexual youth are significantly more likely to consider suicide and to act on suicidal impulses than non-gay youth.³⁷ The experience of harassment at school is correlated with an increased likelihood of attempted suicide among gay youth.³⁸ Although the visibility and social acceptance of gay men have undoubtedly improved in recent decades, the large number of suicides among gay youth in 2010 underscores the reality

that many young people enter adulthood traumatized by anti-gay bullying, harassment and social isolation.³⁹ Poorer mental health outcomes for gay adults are often related to stresses they experienced as adolescents.⁴⁰

State-sanctioned discrimination both reflects and reinforces negative social attitudes toward gay and bisexual men. No federal law protects against employment discrimination on the basis of sexual orientation, and firing an individual because he or she is gay is legal in most states.⁴¹ Fourteen states have no law addressing hate or bias crimes based on sexual orientation or gender identity.⁴² More than 40 states have constitutional provisions or laws that expressly prohibit legal recognition of relationships between members of the same sex.⁴³

Official discrimination against gay men has psychosocial consequences that greatly increase their vulnerability to HIV and other health problems. According to a 2005 national study, LGBT people who resided in states that lacked policies protecting against hate crimes and employment discrimination based on sexual orientation were more likely to suffer from psychiatric disorders than their counterparts in states where such protections had been enacted.⁴⁴ Due to the trauma associated with growing up gay and living in a society in which homosexuality remains highly stigmatized, gay men are significantly more likely than heterosexual men to experience mood or anxiety disorders,⁴⁵ as well as intimate partner violence.⁴⁶ Gay men are also more likely than other men to use multiple illicit substances.⁴⁷



In a sizable segment of gay men, poly-drug use, depression, experience of prior sexual abuse, and intimate partner violence occur together. The linked nature of these health issues has given rise to the term “syndemics,” which describes the factors that combine to increase gay men’s vulnerability. These linked conditions are also strongly associated with unprotected sex and risk of HIV infection.⁴⁸

Unfortunately, healthcare providers are often poorly equipped to provide culturally sensitive, high-quality care and support to address these risks. For example, only 40 percent of adolescent healthcare providers surveyed in upstate New York were aware of the strong, well-documented association between suicide and gay or bisexual identity.⁴⁹ Shame and internalized homophobia may also interfere with the development of an open, trusting relationship between gay men and their healthcare providers; among 452 New York City gay and bisexual men surveyed, 39 percent did not disclose their sexual orientation to their healthcare providers, with African-American and Hispanic men less likely than white men to disclose such information.⁵⁰

Policy reforms and programmatic responses are required to address the social factors contributing to new HIV infections among gay and bisexual men. At a broader societal level, political leadership is needed to eradicate the anti-gay stigma and discrimination that exacerbate HIV-related risks. In addition, men who experience multiple, interrelated psychosocial problems constitute an especially vulnerable subpopulation that requires particularly intensive programmatic focus.

Mitigating Negative Social and Structural Factors: Policy Recommendations

- *Reform laws to promote equality and non-discrimination. Congress should enact the Employment Non-Discrimination Act to protect gay and bisexual workers from workplace discrimination, and repeal the Defense of Marriage Act. States should take steps to recognize and protect same-sex relationships.*
- *Implement and aggressively enforce anti-bullying initiatives in schools—through actions at the federal, state, and local levels—according to the administration’s 2010 anti-bullying directive.*
- *Undertake intensive training and technical assistance to build the capacity of healthcare providers to deliver culturally competent, high-quality care to gay and bisexual men.*
- *Significantly increase access to, and utilization of, mental health and substance abuse services specifically designed for gay and bisexual men.*
- *Increase support for LGBT clinics.*



Photo: © Nikolay Mamluke/Dreamstime

Gay and bisexual men have demonstrated enormous resilience in the face of the HIV/AIDS challenge.

New Strategies to Reduce Sexual Risk Behaviors

The limitations of individual-focused behavioral strategies underscore the need for new approaches that encourage safer sexual behavior and reduce the probability of transmission during any single instance of risk behavior. Several promising strategies should be urgently pursued:

- ***Community-Level Interventions.*** Community-level interventions operate as a “social vaccine,” forging healthy community norms and mobilizing community members to perpetuate and reinforce standards for safe behavior. CDC long ago recognized the value of community-level interventions,⁵¹ although relatively little research or CDC funding in this area has focused on gay and bisexual men. This represents a major missed opportunity, as community-generated programs played a key role in the early prevention successes in urban gay communities.⁸ Gay men have demonstrated enormous collective resilience in the face of the HIV/AIDS challenge,⁵² suggesting multiple potential avenues for the development of community-centered prevention strategies. In addition, the healthcare reform legislation enacted in 2010 authorized community transformation grants, providing new funding beginning in FY2011 for community-centered programs that address health disparities and promote healthy community norms and practices.
- ***Prevention Coverage.*** Most CDC-funded prevention programs are delivered by community-based organizations or state and local health departments. While these programs play a critical role in delivering

essential HIV prevention services to gay and bisexual men, only a minority of gay men are reached through these channels. Inclusion of HIV testing and prevention counseling in the Essential Health Benefits package defined by the secretary of health and human services would help leverage the Affordable Care Act to expand coverage and uptake of prevention services, potentially mobilizing tens of thousands of healthcare providers nationwide to become active prevention agents for their gay and bisexual patients. This approach would dramatically broaden the range of sources

of HIV prevention information and services to gay and bisexual men.

- *New Prevention Technologies.* In addition to reducing the frequency of risky sexual behavior, effective HIV prevention for gay men also aims to decrease the probability that a single sexual act will result in transmission. In 2010, results from an NIH-supported study indicated that daily pre-exposure prophylaxis (providing ART to HIV-negative people) reduced the

Recommended Actions for Federal, State, and Local Agencies

Recommended Actions by the Centers for Disease Control and Prevention (CDC)

- * Allocate new funding to community-level prevention interventions for gay and bisexual men.
- * Critically examine prevention portfolio to determine the optimal combination of prevention approaches to reduce new infections among gay and bisexual men.
- * Take steps to ensure that allocations for both CDC's directly funded prevention programs and state and local programs supported with CDC funds reflect available evidence regarding the epidemiology of HIV in the U.S.
- * Encourage state and local health departments to merge or link planning processes for HIV prevention and HIV care.
- * Encourage state and local health departments to allocate a portion of HIV counseling and testing funds toward marketing initiatives to increase testing uptake among gay and bisexual men.
- * Capitalize on the 12-city enhanced prevention project to build the evidence base for effective, holistic, outcome-driven HIV prevention for gay men, taking steps to capture synergies between the efforts of diverse federal agencies, including but not limited to CDC, HRSA, SAMHSA, and CMS.
- * Intensify outreach to healthcare providers and professional medical societies to increase adherence to CDC recommendations for routine HIV screening in healthcare settings and for annual HIV testing for all gay and bisexual men.
- * Require state and local recipients of HIV counseling and testing funds to have meaningful, well-enforced mechanisms to ensure prompt linkage to HIV primary care of people who test HIV positive.
- * Support demonstration projects of pre-exposure prophylaxis (PrEP) for gay and bisexual men.
- * Intensify funding and technical support to state and local health departments for community viral load monitoring, and use surveillance findings to inform interventions to reduce viral load in a larger percentage of people.
- * Undertake field-based research on efficacious gay-focused behavioral interventions to assess their actual public health impact and to determine the feasibility of bringing such interventions to scale.
- * Prioritize strategies to promote healthy behaviors among gay and bisexual men in the roll-out of community transformation grants under the Affordable Care Act.

likelihood of infection by 44 percent among the study group, with significantly higher protection among those who took the study drug regularly.⁵³ Pre-exposure use of ART (PrEP) is merely the latest step in the growth of preventive uses of these drugs.⁵⁴ Other new prevention methods for gay men, such as rectal microbicides, are also being investigated, offering the prospect of an ever-expanding toolkit to lower the per-act odds of transmission. As new prevention tools emerge, immediate steps will be needed to assess and capture their prevention potential.

Reducing Risk: Policy Recommendations

- *Implement community-level approaches and conduct research to build the evidence base for these approaches.*
- *Increase prevention coverage by including HIV testing and prevention services in all standard medical benefits packages for third-party payers.*
- *Urgently undertake pilot studies to inform strategies to deliver pre-exposure prophylaxis.*

This issue brief was produced by amfAR and Trust for America's Health and was authored by Mike Isbell, an independent consultant.

Recommended Actions by the Health Resources Services Administration (HRSA)

- * Implement incentives to reward Ryan White jurisdictions that reduce unmet need for HIV primary care.
- * Capitalize on all available resources (including but not limited to Ryan White programs and the Bureau of Health Professionals) to intensify training and technical assistance for healthcare providers to help them deliver culturally competent, high-quality care to gay and bisexual men.
- * Support the design and evaluation of programs to link people with diagnosed HIV infection to care and to ensure continuity of high-quality care, focusing particular attention on high-need populations, such as African-American gay men.
- * Implement incentives to reward Ryan White jurisdictions that increase rates of HIV treatment adherence.
- * Work closely with local staff in the 12-city enhanced prevention project to coordinate and integrate HIV prevention and treatment for gay men.
- * Make routine HIV screening part of the standard of care at all community health centers.
- * Increase support for LGBT community health centers as a component of the community health center expansion under the Affordable Care Act.

Recommended Actions by the Substance Abuse and Mental Health Services Administration (SAMHSA)

- * Make routine HIV screening part of the standard of care at all SAMHSA-funded sites providing substance abuse and/or mental health services.
- * Prioritize increasing the availability, accessibility, quality, and cultural competence of substance abuse and mental health services for gay and bisexual men.
- * Promote integration of CDC, HRSA, and SAMHSA HIV-related funding as part of federal strategic planning, local service planning, and service delivery.
- * Maximize use of the HIV set-aside funds in the SAMHSA program to strengthen substance abuse and mental health services for gay and bisexual men.

Recommended Actions by the Centers for Medicare and Medicaid Services (CMS)

- * Make routine HIV screening a high-profile policy within the Medicaid program, including an emphasis on emergency department encounters.
- * Permit states to reimburse for adherence services and other case management services under Medicaid.
- * Use the Ryan White holistic care model as a standard for development of patient-centered medical homes for Medicaid recipients.

Recommended Action by Department of Education

- * Aggressively enforce the administration's 2010 anti-bullying directive and assist and encourage local and state education authorities in instituting policies and programs aimed at eliminating anti-gay bullying.

Recommended Actions by State and Local Governments

- * Build local capacity to monitor and respond to surveillance data on community viral load.
- * Maximize flexibilities under Ryan White to increase access to HIV testing, swift linkage to care, continuity of care, and treatment adherence.
- * Remove potential barriers to testing uptake, such as onerous counseling and consent requirements.
- * Implement monitoring systems to assess the degree to which HIV prevention funding follows the epidemic, and take steps to address imbalances in resource allocations.
- * Implement local initiatives to increase HIV testing uptake, with particular attention to African-American gay men and other high-need groups.
- * Proactively use opportunities under the Affordable Care Act (e.g., community health worker program and community transformation grants) to seek new funding for community-based prevention and treatment strategies for gay and bisexual men. Particular attention should be given to the needs of African-American gay men and other high-need groups.
- * Integrate CDC, HRSA, and SAMSHA HIV-related funds at the community planning and service delivery levels.
- * Implement public awareness and social change communications strategies to increase tolerance for sexual diversity and reduce anti-gay stigma and discrimination.
- * Implement and rigorously enforce anti-bullying rules in local schools.
- * Enact legislation to reduce discrimination toward LGBT people, recognize same-sex partners, and eradicate hate crimes.

Implementation of Affordable Care Act: Recommended Actions

- * Harmonize recommendations by the CDC and the U.S. 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.
- * Include the HHS HIV/AIDS treatment guidelines as part of the essential health benefits package, and use 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.
- * Require HIV-experienced providers 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.
- * Ensure 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.
- * Use new workforce initiatives to expand the number of HIV providers and improve the LGBT-related cultural competence of health providers in general.
- * Effectively use community transformation grants to establish new programs that promote healthy social norms and behaviors among gay and bisexual men.
- * Take specific steps to educate gay and bisexual men about new health coverage opportunities and to link them to affordable insurance options.
- * Give priority to robust, comprehensive coverage of effective, culturally appropriate mental health and substance abuse services for gay and bisexual men.

Recommended Actions by Congress

- * Take steps to eliminate funding shortfalls, waiting lists, and coverage restrictions for the AIDS Drug Assistance Program.
- * Enact the Employment Non-Discrimination Act to provide nationwide protection to LGBT workers.
- * Repeal the Defense of Marriage Act.
- * Ensure full and timely implementation of the Affordable Care Act.

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