



Respectfully submitted by:

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Presently, HIV prevention in the U.S. lacks the resources and comprehensiveness that will significantly drive down HIV incidence rates.^{1 2} I ask that you consider the following:

- ❑ Serious HIV-related health disparities, often fueled by stigma and discrimination, continue to undermine HIV prevention efforts in communities of color;^{3 4 5 6}
- ❑ Men who have sex with men continue to make up the majority of new HIV infections nationally, across race and ethnicity, with Black and Latino gay men especially hard hit;^{7 8 9 10 11} and
- ❑ Only five of the CDC's 57 recommended evidence-based interventions specifically target gay men and only two is designed to address the needs of gay men of color.^{12 13 14}

In addition, and just as important to consider are these facts:

- ❑ Substance abuse prevention and treatment are under-funded and not routinely viewed as integral to overall HIV prevention efforts;
- ❑ Structural interventions are not commonly researched or endorsed even when sound science support their broad-based adoption, as is the case with multi-component syringe access and disposal programs;
- ❑ Other than new HIV treatments, we have not yet harnessed the full prevention potential of other promising biomedical interventions, including pre-exposure prophylaxis (PrEP) and microbicides; and
- ❑ Many science-based prevention interventions are difficult for community-based providers to implement because they were tested under research conditions that are different from real life settings or tested on populations other than those currently most vulnerable to HIV infection.

While HIV testing and treatment are crucial in our fight against AIDS, a singular focus on testing and treatment, is inadequate and narrows an already sparse continuum of prevention strategies. We need a



comprehensive national HIV prevention plan in the U.S. At its core, such a plan would:

1. **Work to eliminate disparities in health access and stigma associated with HIV, drug use, and homosexuality.** The personal benefits of knowing one's HIV-status early are lost on those who must overcome the significant barriers to treatment and persistent stigma that keep some away from care;
2. **Target interventions to those most at risk for HIV exposure and keep a steady and respectful focus on the prevention needs of gay and bisexual men, substance users, and women at sexual risk.** The alternative is that we accept silence and denial about sexuality, drug use, and economic inequality, permitting stigma and discrimination to compromise our prevention efforts;
3. **Ensure that priority be given to expanding social science and intervention research aimed at gay and bisexual men especially men of color;**
4. **Make the prevention and treatment of drug and alcohol addiction central to HIV prevention efforts.** The risk for HIV infection is heightened by drug and/or alcohol abuse;^{15 16 17}
5. **Research and adopt community-level and structural interventions to complement behavior modification programs.** Structural-level changes buttress the gains in behavior change made through individually geared prevention interventions by addressing the social factors that underlie HIV vulnerability;¹⁸
6. **Support continued HIV treatment, vaccine, and other bio-medical interventions that are safe, ethical, and show promise of efficacy;** and finally
7. **Balance the policy of promoting pre-packaged evidence-based HIV prevention interventions by supporting and evaluating more localized, “bottom-up,” and collaborative HIV prevention strategies.** It is critical to respect on-the-ground responses to the HIV/AIDS epidemic by protecting local control over how HIV



prevention strategies are developed, researched, prioritized and implemented.

HIV prevention efforts in general have not received the funding needed to make them ubiquitous and continuous. Nor have our resources been adequately targeted to reach those at highest risk for infection. We need a comprehensive national HIV prevention plan in the U.S. that clearly calls for culturally relevant, multilevel, combination approaches that are well funded, targeted, and sustained over many years.¹⁹

- ¹ Holtgrave, D.R. and Kates, J. HIV incidence and CDC's HIV prevention budget: An exploratory correlational analysis. *American Journal of Preventive Medicine*, Pub ahead of print, 2006 Dec.
- ² Holtgrave, D.R. and Kates, J. HIV incidence and CDC's HIV prevention budget: An exploratory correlational analysis. *Am J Prev Med*, 2007; 32(1):63-67.
- ³ Turner, et al. Delayed medical care after diagnosis of persons infected with HIV. *Archives of Internal Medicine*, 2001;Vol.16.
- ⁴ Supplemental HIV Surveillance Study Project. L.A. County, Department of Health Services, January 2000.
- ⁵ United State Census Bureau, July 2001.
- ⁶ Brodie, M. et al. The 2002 National Survey of Latinos. Pew Hispanic Center/Kaiser Family Foundation, December 2002.
- ⁷ Valleroy et al. HIV prevalence and associated risks in young MSM. *JAMA*, 2000;284:198-204.
- ⁸ Diaz, R. Ayala, G. Social discrimination and health: The case of Latino gay men and HIV risk. 2001. Commissioned Monograph. National Gay and Lesbian Task Force.
- ⁹ Centers for Disease Control and Prevention. HIV incidence among young men who have sex with men--seven U.S. cities, 1994-2000. *MMWR Morb Mortal Wkly Rep* 2001;50(21):440-4.
- ¹⁰ Blair JM, Fleming PL, Karon JM. Trends in AIDS incidence and survival among racial/ethnic minority men who have sex with men, United States, 1990-1999. *JAIDS*, 2002; 31(3):339-47.
- ¹¹ CDC. Cases of HIV infection and AIDS in the United States and Dependent Areas, 2005. *HIV/AIDS Surveillance Supplemental Report* 2007;17.
- ¹² Mays, V.M., Cochran, S.D., Zamudio, A. HIV prevention research: are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology*, 2004;30:78-103.
- ¹³ Lyles, C.M., Kay, L.S., Crepaz, N., Herbst, J.H., Passin, W.F., Kim, A.S., et al. Best-evidence interventions: Findings from a systematic review of HIV Behavioral interventions for US populations at high risk, 2000-2004. *American Journal of Public Health* 2007;97(1):133-143.
- ¹⁴ Millet, G.A., Flores, S.A., Peterson, J.L., and Bakeman, R. Explaining disparities in HIV infection among black and white men who have sex with men: a meta-analysis of HIV risk behaviors. *AIDS*, 2007; 21: 2083-2091.
- ¹⁵ Parsons, J.T. Correlates of sexual HIV transmission risk behaviors among HIV+ MSM. National HIV Prevention Conference. 1999. Abstract No. 181.
- ¹⁶ Strathdee et al. Determinants of sexual risk taking among young HIV- gay and bisexual men, *Journal of AIDS Human Retrovirology*, 1998; 19:61-66.
- ¹⁷ Stall, R., Mills, T.C., Williamson, J., Hart, T., Greenwood, G., Paul, J., et al. Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health*, 2003; 93(6):939-42.
- ¹⁸ Gupta, R.A., Parkhurst, J.O., Ogden, J.A., Aggleton, P., and Mahal, A. Structural approaches to HIV prevention. www.thelancet.com, August 30, 2008; Vol. 372.
- ¹⁹ Coates, T.J., Richter, L., and Caceres, C. Behavioral strategies to reduce HIV transmission: how to make them work better. www.theLancet.com, August 6, 2008.