



# LOS ANGELES COUNTY COMMISSION ON HIV

**POLICY  
BRIEF #8**  
October 9, 2009

## National HIV/AIDS Strategy (NHAS) Community Discussions

Since the beginning of the HIV/AIDS epidemic in 1981, the US has not successfully developed and implemented a national strategy to guide the federal government's HIV/AIDS-related decisions. In 2007, HIV/AIDS advocates (including the Commission, in its Reauthorization Principles) began pressing more aggressively for a coordinated, strategic and effective strategy to steer the course of the federal response to the HIV/AIDS epidemic. Additional information about the community's Call for a NHAS is at: [www.nationalaidsstrategy.org](http://www.nationalaidsstrategy.org).

During his presidential campaign, candidate Obama pledged that his administration would implement an HIV/AIDS national strategy to lower HIV incidence, increase access to care, and reduce HIV-related health disparities. On August 21, 2009, President Obama announced that his Office of National AIDS Policy (ONAP) would be hosting a series of Community Discussions around the country in the fall to facilitate the development of the NHAS.

### LA County's NHAS Community Discussion

The NHAS Community Discussion in LA is scheduled for Sunday, October 18, 2009 from 4:30 pm to 6:30 pm at the Hollywood High School Auditorium (Hollywood High School, 1521 North Highland Avenue, LA, <http://www.hollywoodhighschool.net>). People attending the Community Discussion should get there by 4:00 pm for check-in and seating.

### IMPORTANT TIP(S):

**What is a National Strategy?** A national strategy is a blueprint that motivates policy makers and leaders to take consistent action on a particular issue—in this case, HIV/AIDS. A strategy addresses issues of national significance, but rarely singles out specific local concerns. When providing comments for the NHAS, try to think about the issue's relevance nationally. For example, the national strategy might not be able to solve why you can't get local dental care, but it can recommend that dental care become a higher priority. Or, if California's ADAP doesn't cover a drug you need, consider proposing that ADAPs nationally offer more medications.

Although all are welcome to the Community Discussion (and will be allowed to register and check-in at the Auditorium), people planning on attending are encouraged to RSVP at <https://www.cmpinc.net/ONAP>. Registering on-line will not only expedite check-in, but meeting organizers will send you additional information about the event in advance.

### Issues of Particular Interest to LA County's HIV Community

The following brief outlines some of the key principles important to the HIV/AIDS community in LA County, to People with HIV/AIDS (PWH/A), and ways of effectively participating in the Community Discussion.

Over the course of the past several years, the Commission has identified and adopted positions to advance the effectiveness of HIV/AIDS care, treatment and prevention. Those positions have been detailed in various Commission publications, such as its Reauthorization Principles, its legislative agendas, and in its health reform activities. Following are several key issues (in no particular order) that the Commission believes are critical to the development of an effective, comprehensive NHAS.

### **Process**

In its Ryan White Reauthorization Principles ([http://www.hivcommission-la.info/cms1\\_091812.pdf](http://www.hivcommission-la.info/cms1_091812.pdf)), the Commission called for a national HIV/AIDS strategy and a comprehensive national care, treatment, prevention and research plan. Accordingly, the Commission firmly supports the Presidential intent to develop a plan that will guide federal and local HIV/AIDS decision-making in the years to come.

The plan itself will play a critical role in how HIV/AIDS policy is shaped, and the advocacy community should pay due diligence to how the plan is drafted and created. As development of the NHAS unfolds, ONAP and the Administration must clarify the outcomes they expect from NHAS. How will we, as a community, evaluate and measure its effectiveness? How will local input continue to be incorporated as the document is crafted? And, how will the strategy be implemented once the document is completed?

**Key Issues:** While the National HIV/AIDS Strategy is a good idea, we need to know how it will be implemented, and how consumer and stakeholder input will continue to be incorporated as it is drafted.

### **Vision**

The strategy must detail both short-term fixes and long-term approaches. There are not always easy solutions to the challenges

of HIV/AIDS. It is important that other initiatives or news not distract the NHAS from its primary objectives. While the promises of health care reform may address the needs of some HIV-impacted communities, there is the potential that other populations will find themselves with less health care access. Recent reports of a possible vaccine will not, if proven effective, end HIV transmission, and may lead to greater disparities for those populations without access to it. The NHAS must realistically underscore a long-term commitment needed to effectively mitigate the impact of HIV/AIDS.

**Key Issues:** Possibilities of health care reform, a vaccine, and/or other progress will not solve all HIV challenges. We must continue addressing issues like HIV transmission and disparities in low-income communities and populations of color.

### **Public Health**

The NHAS should take active steps to re-frame HIV/AIDS as a public health condition, not an issue of gender, sexuality, nationality, immigration or other characteristics often ascribed to it. Too often, HIV/AIDS decisions get mired in identity politics when HIV/AIDS policy should be developed based on sound public health practices and concepts. As a chronic, communicable and potentially terminal disease, HIV/AIDS requires a unique public health response. Similarly, HIV/AIDS represents a continuum of disease progression along which distinct disease classifications (e.g., the difference between HIV and AIDS) are no longer as relevant. Reshaping HIV/AIDS as a public health issue will help “destigmatize” the people who are infected with it, and the populations that are challenged most severely by it.

**Key Issues:** HIV/AIDS is a public health issue and not one of identity. We should respond to HIV/AIDS as a public health condition without stigmatizing who’s impacted.

### **Local Conditions**

Stakeholders providing testimony or comment on the NHAS should use the opportunity to educate ONAP and the other NHAS framers about LA County's local conditions. The HIV/AIDS epidemic on the West Coast is dramatically different from other parts of the country: predominant ethnic and racial populations—where the HIV/AIDS impact varies—are different on the West Coast. So, too, are the local co-morbidities that often accompany the disease. The West Coast epidemic is more the result of sexual behavior (e.g., men having sex with men) than substance use. Although the State's budget cuts have overwhelmed the counties' public health systems, LA County continues to make a financial commitment broadening the reach of the local response. Use your dialogue to help craft the NHAS into a plan that addresses the unique needs of LA County and the West Coast by describing how your experiences may differ from your counterparts in other parts of the country.

**Key Issues:** The HIV/AIDS epidemic in LA County is different than other parts of the country. The NHAS should reflect the unique needs/challenges of all parts of the country. Use your personal experiences to describe how facing HIV/AIDS in LA is different/unique.

### **Funding**

While the NHAS should not solely focus on funding issues, the importance of adequate funding—especially to California and LA County in their current economic crises—cannot be ignored nor underestimated. Failure of past federal HIV/AIDS funding appropriations (which have flat-lined in past years) to keep pace with need has significantly hindered effective local response. In California, a declining HIV/AIDS response has been further compounded by the Governor's budget cuts of \$82.5 million to the Office of AIDS. LA County's share of the cuts is \$13+ million.

Recognizing similar budget scenarios in many states across the country, the NHAS should call for increased appropriations to (not an exclusive list) the Health Resources and Services Administration (HRSA) for the Ryan White Program; the Centers for Disease Control and Prevention (CDC) for prevention efforts; the Department of Housing and Urban Development (HUD) for Housing Opportunities for Persons With AIDS (HOPWA) support; the Substance Abuse and Mental Health Service Administration (SAMHSA) to serve people with multiple morbidities; and the National Institutes for Health (NIH) for research.

**Key Issues:** Federal funding for HIV/AIDS has not increased in years, but must keep pace with the increased number of people with HIV/AIDS who rely on publicly funded HIV services. California's budget cuts have created an even greater need in the State and LA County, in particular.

### **Federal Intervention**

In light of the State budget cuts, LA County has had to absorb the cost of therapeutic monitoring vouchers, home and community-based care, early intervention programs and most prevention activities (Health Education/Risk Reduction, counseling and testing), among other service costs—while facing myriad other public health budget cuts from the State and a declining economy. In turn, services such as peer support, legal services, treatment education, case management and medical nutrition therapy have been reduced or eliminated. State leaders have already said that the State's budget cuts next year may lead to additional HIV/AIDS cuts, including to the AIDS Drug Assistance Program (ADAP). Prevention services—which are the only long-term strategy to stem the epidemic—have been all but abandoned by the State, and left to local jurisdictions to address.

The NHAS should underscore the need for federal intervention to directly stimulate or preserve State and local economies, similar to the type of support that has been provided directly to Wall Street firms, banks, insurance companies and car manufacturers. If the Administration is using the mantra “too big to fail,” then California, as the world’s eighth largest economy, certainly meets that standard. To date, direct federal stimulus support for California has amounted to approximately \$8 billion—when the State faced a budget deficit this year three times as much, and may face similar deficits in future years. The typical political response that such intervention sets “a dangerous precedent” does not acknowledge that the combined state deficits throughout the country only add up to slightly more than the sum of the bail-outs that the federal government provided to AIG.

**Key Issues:** California’s budget cuts have harmed HIV/AIDS services locally more than any other factor this past year. The federal government needs to play a more proactive role helping states recover from the nation’s economic crisis. Why is it okay to bail-out private companies and not much larger state economies?

### **Continuum of Care**

The NHAS offers the HIV/AIDS community the unique opportunity to review and revisit a massive HIV/AIDS infrastructure that may no longer reflect the actual needs of an effective public health response to HIV/AIDS. Streamlining fragmented HIV/AIDS funding and accompanying requirements—for example, eliminating the “silos” that lead to redundancies, duplication of effort, and service delivery confusion—will improve the federal role in the HIV/AIDS response. Federal funding and grants based on prevalence and incidence and other evidence-based measures of need, rather than competitive and subjective scoring and evaluation, will channel resources more appropriately.

Recognizing that the “emergency” nature of HIV/AIDS is no longer as prevalent, but the need is just as “urgent,” would give local jurisdictions more flexibility to plan their service systems more effectively. Abandoning the concept that federal funding can only be used as “last resort”—when, in fact, California’s counties are the last resort for patients without any other financial resources—would better target federal funding for complementary and supplemental support that can be used more successfully in local areas.

**Key Issues:** We can improve how we manage HIV/AIDS services nationally, better coordinate funding streams, base funding on prevalence/incidence rather than subjective scoring, and provide federal funding in such a way to give local areas more flexibility to deliver services according to need.

### **Prevention**

The federal government must re-assert its primacy in the nation’s HIV/AIDS prevention response. The last several years have shown us that when economies sour, decision-makers cut prevention activities first—ignoring the potential long-term impact by accelerating the epidemic that such actions may have. Prevention is easier to trim than care and treatment: positive prevention results are not as tangible or obvious, although study after study substantiates the wisdom of investing in a comprehensive prevention effort. Failure to support adequate counseling and testing and other prevention efforts leads to long-term public health failure that will end up costing billions more in resources and millions more in lives later. States have recently demonstrated that they do not have the capacity to provide the necessary prevention leadership during crises, and it falls to the federal government to do so. The federal government must reverse its recent course of reducing prevention funding and re-dedicate itself to support prevention as a principle public health core element.

**Key Issues:** The federal government must reassume its role in prevention leadership. Federal and state cuts to prevention have become commonplace, in spite of possible negative long-term consequences. That trend must be reversed.

### ***HIV Counseling and Testing (HCT)***

The fine distinction between HCT as prevention, and medical and ancillary services as treatment, has become increasingly illogical in a public health response that identifies people with HIV and move them seamlessly into treatment and support. Yet the structure of the federal response separates HCT and care, hindering collaborative and efficient partnerships and linkages. Recent additions to the pending Ryan White Reauthorization/Extension legislation notwithstanding, the NHAS should detail specific plans to integrate HCT and care/treatment services in federal and local programs nationwide, driving an architecture of seamless service delivery from diagnosis through care. The Commission is not only committed to making voluntary HCT available to everyone, but expanding access to HCT, making HCT more routine in medical settings (e.g., with STD screening, opt-out offers in all routine medical appointments and emergency room visits, etc.), and requiring Medicaid/Medicare and private insurance companies to cover voluntary HCT.

**Key Issues:** HIV Counseling and Testing (HCT) should be integrated with medical care, and become more routine in medical care settings and visits.

### ***Ryan White Program***

The Ryan White Program is the core of the federal government's response to HIV/AIDS, and is the largest non-entitlement funding source for HIV/AIDS care and treatment. The NHAS should not plan for a day without the

Ryan White Program, but should envision how Ryan White may need to accommodate efforts to reform the health care delivery system. It is clear—even when considering the most generous health care reform proposals currently under review—that a number of special populations will be squeezed out, and that even greater disparities could result. Ryan White will have to adapt to address the needs of those populations and to provide additional HIV specialty services that may be necessary as all health care is further mainstreamed. The NHAS should include specific plans to strengthen the Ryan White Program to ensure that all populations impacted by HIV/AIDS have access to essential life-saving health care and support services.

**Key Issues:** Even with advances in health care reform, the Ryan White Program will still be needed for HIV specialty services and to provide care to populations that are left out of health care reform innovations.

### ***AIDS Drug Assistance Program (ADAP)***

The NHAS can also be used to establish thresholds below which the federal commitment to Ryan White cannot waver. Governor Schwarzenegger's administration and State public health leaders have suggested that changes and reductions to the State's ADAP program may be needed next year in the face of additional budget deficits. Among the ADAP modifications that have been previously proposed are (not an exclusive list): reducing eligibility, establishing greater co-pays, wait lists and a variety of other means for achieving ADAP savings. California has long prided itself for the one of the best ADAPs in the country, while many other states already have waiting lists and significantly reduced access. Framers of the NHAS should understand that ADAP is the key to federal care and treatment response to HIV/AIDS, and measures need to be articulated and implemented that strengthen ADAP in wait-list states and preserve ADAP stability in states like California.

**Key Issues:** California leaders are already considering cuts and modifications to ADAP, paralleling problems with ADAP access in other parts of the country. The NHAS should include mechanisms to expand and preserve ADAP across the country.

### Medicaid/Medicare

Most low-income patients with HIV/AIDS who do not qualify for Medicaid and/or Medicare turn to Ryan White and/or County-funded services for medical and related care. Thus, expanding Medicaid and Medicare eligibility and services reduces the financial burden on local systems while not appreciably increasing the costs to the federal health care system. Increasingly, the strength and structure of the Medicaid and Medicare systems have become focal points of discussion in the health care reform dialogue. There are several Medicaid/Medicare solutions that the Commission and other local stakeholders have been aggressively advocating for many years—that should be incorporated into health care reform or implemented independently:

- ① Increase eligibility for Medicaid for uninsured people to incomes of \$20,000/year (families of four, \$42,000/year per year)
- ① Allow states to provide Medicaid coverage for people with HIV with even higher incomes, as proposed in the Early Treatment for HIV Act (ETHA).
- ③ Ensure access to quality health care by establishing a comprehensive, standard Medicaid benefits package that is available in every state.
- ④ Keep Medicaid/Medicare health care services and prescriptions affordable for everyone by minimizing consumers' out-of-pocket costs.
- ⑤ Count ADAP as a True Out-Of-Pocket (TrOOP) cost to mitigate the Medicare Part D “donut hole.”
- ⑥ Increase the federal contribution to state Medicaid programs during periods of economic crisis.

- ⑦ Improve access to health care by eliminating the two-year Medicare waiting periods for people with disabilities.
- ⑧ Encourage the Centers for Medicaid/Medicare Services (CMS) to grant more federal Medicaid waivers (such as California’s Medicaid Managed Care waiver) allowing local jurisdictions to innovate HIV specialty services within the context of entitlement programs.

**Key Issues:** The previous section outlines a number of specific proposals to expand Medicaid/Medicare services for people with HIV/AIDS, and to reduce the burden and cost for local health care systems.

### Access

As a chronic disease, HIV/AIDS can be managed—but HIV/AIDS is not always manageable for people who are facing its many challenges and multiple morbidities. HIV/AIDS has increasingly become a public health condition to which impoverished and disenfranchised communities are most vulnerable. Medical care and medications alone are no longer a sufficient response alone. Other innovations are needed, and should be addressed in the NHAS, to improve access to care, treatment and prevention. The NHAS should call for efforts to strengthen the health care work force, and for assurances that providers are reimbursed fairly, equitably and rapidly, to help promote, protect and enhance access to their vital services.

Reduced access and greater disparities lead to higher costs in care and lives. When clients cannot access the health care system—for whatever reason—LA County ends up paying more for the increased care later on: the higher cost of more advanced care resulting from lack of early detection and treatment, and the costs of communicable disease spread caused by less effective prevention, education, early diagnosis and entry into care efforts. The Ryan White Program may not be

able to address all of the poverty needs of people with HIV/AIDS alone, but the NHAS should articulate a vision how our nation can better ensure access and reduce disparities for disempowered communities. Similarly, the NHAS should attempt to define the social determinants of poverty, how they may negatively impact the effectiveness of HIV care and prevention, and how to address them for people with HIV/AIDS.

**Key Issues:** Access to HIV care and prevention is problematic for many disenfranchised populations. The NHAS should address these concerns with proposals to upgrade the HIV health care workforce, reduce disparities and respond to the social determinants of poverty that often lead to ineffective HIV care.

### **Uninsured PWH/A**

As Congress debates health care reform, it is critical for the HIV/AIDS community to insist that reform provisions adequately reflect the health care needs of people with HIV/AIDS. A larger proportion of residents in California are uninsured and rely on public health programs than in other parts of the country. Private insurance costs more in California, and a smaller percentage of people are eligible for group coverage than the national average. Patients with HIV receiving Ryan White- and County-funded services are considered uninsured from a national perspective, so any federal efforts to assume a larger share of the uninsured through health care reform or expansion of Ryan White benefits will disproportionately reduce the burden on California and LA County. Key health care reform provisions that will dramatically enhance health care coverage for people with HIV/AIDS should be included in the NHAS, such as proposals to expand and improve private health insurance options, and specific guarantees that everyone has access to an affordable, comprehensive, quality health insurance plans.

**Key Issues:** California shares a greater burden of uninsured residents and higher health care costs. Efforts to address the needs of the uninsured in health care reform must include specific provisions for PWH/A.

### **HIV and Aging**

Due to medical and pharmaceutical responses to HIV/AIDS in the past decade, people with HIV/AIDS are living longer and healthier. As a result, HIV providers are confronted with new, expanding populations of people over 50 with HIV/AIDS. The aging HIV-infected population comprises both long-term survivors and the newly infected/diagnosed—both populations growing at faster than average rates.

The aging HIV/AIDS population presents new health care and economic challenges. There is still little known about how HIV interacts with the onset of age-associated health conditions, such as diabetes, renal complications, brain disorders and osteoporosis, to name a few. Oral health needs accelerate with age and HIV, and presenting mental illness identification, symptoms and therapies may differ for older HIV-infected populations. Older PWH/A population face increased un- and under-employment risks, due to of the onset of multiple health conditions related to the combination of HIV and age—jeopardizing an already precarious health care response with even more economic difficulties and additional disability burdens. To the degree they are known, the NHAS should identify these current and future challenges and begin outlining a response, or they could easily overwhelm the HIV system of care in the years to come.

**Key Issues:** PWH/A are aging and older people are becoming HIV-infected at faster rates—raising questions of how to respond to their different health and economic risks that should be addressed in the NHAS.

### **Undocumented Patients**

One group of the uninsured is being left out of the health care reform equation: undocumented residents. As politicians clamor to pledge that undocumented patients will not be covered by any of the health care reform proposals, they shift the burden of caring for these communities to local jurisdictions. Proper public health does not recognize national origin or legal status, and communicable diseases spread faster when they go unchecked in population subsets. Aside from the moral questions of a society unwilling to attend to its neighbors' basic health needs, failure to address the care, treatment and prevention needs of undocumented people with HIV/AIDS in our country accelerates the spread of HIV, creating a public health threat.

The undocumented turn to the counties' health care systems as a last resort—often only in emergency situations (which invariably cost more)—the cost of which is shouldered by the counties' and State taxpayers. Because the largest proportion of the country's undocumented residents live in California and other border states, the federal government's failure to provide sufficient funding for their care and treatment becomes an “unfunded mandate” expected of the local jurisdictions (meaning laws and common sense require a local response, but the federal assistance is lacking). If health care reform is enacted in the future, the Ryan White Program may be the only source of federal support for undocumented people with HIV/AIDS besides the counties' declining financial coffers. It is critical for LA County stakeholders to strenuously advocate the preservation of the Ryan White Program in the NHAS to protect health access for populations like the undocumented, regardless of other health reform outcomes.

**Key Issues:** Access to health care for the undocumented must be preserved through the Ryan White Program. It will not be addressed in health care reform and will create an undue financial burden on California.

### **Quality and Efficiency**

Federal resources and attention should be targeted towards quality, equity and efficiency. Quality, accountability and efficiency at the local level should be rewarded to encourage increased focus on improving health care delivery, to better use resources for stronger health outcomes, to recognize variations in local needs, and to target support/technical assistance for those purposes. The new federal emphasis on “comparative effectiveness research” should be embraced by HIV providers, as health care stakeholders nationwide seek to define better ways of delivering care and generating improved health outcomes, and should be addressed in the NHAS.

**Key Issues:** Quality and effectiveness of service delivery and care must become a top priority, and the NHAS should encourage rewarding local areas for improved HIV health care delivery and outcomes.

### **Effectively Participating in the NHAC Community Discussion**

The following information is designed to help stakeholders present the most effective public testimony at LA's Community Discussion on October 18<sup>th</sup>. Strong and reasoned public participation will help shape a results-oriented National HIV/AIDS Strategy. The following text is provided courtesy of the HIV Prevention Justice Alliance and Women Organized to Respond to Life Threatening Diseases.

#### **Making a Difference**

Your voice is important—and your carefully thought-out recommendations could have a significant impact on ONAP and the inter-governmental agency panel charged with creating the NHAS. At LA's Community Discussion on the 18<sup>th</sup>, please share your ideas on how best to deliver and coordinate HIV prevention, care, treatment to achieve NHAS goals.

**Three NHAS Goals:**

- 1) Reduce HIV incidence,
- 2) Increase access to care, and
- 3) Reduce HIV-related health disparities.

**IMPORTANT TIP(S):**

**Creating Effective Public Testimony:** Your voice is important—and your recommendations could shape an effective NHAS:

- **Make it personal:** talk about who you are and what expertise you bring (as a person living with HIV, someone working in the field, a concerned community member).
- **Don't just complain:** offer solutions (talk about what's working, in addition to what can be done better).
- **Keep your recommendations succinct and to the point:** brief and to-the-point comments may have more impact than long-winded testimonies.

**Preparation Worksheet**

The HIV Prevention Justice Alliance/Women Organized to Respond to Life Threatening Diseases have created a worksheet to help you conceptualize and collect your thoughts in preparation for public testimony at the Community Discussion. The "Work Sheet to Help Prepare Testimony on the National HIV/AIDS Strategy" is attached, and can help stakeholders pull together the most effective and compelling testimonies they can provide.

**Training**

Some local organizations have agreed to provide trainings prior to the Community Discussion in order to help prepare community members' testimonies and to facilitate a more focused and organized discussion at the event. Two of these trainings are:

**Black AIDS Institute**

Tuesday, October 13, 2009, 6:00 – 8:00 pm

1833 West 8th Street, Suite 200  
Los Angeles, CA 90057  
Light dinner served

RSVPs can be sent to [programs@blackaids.org](mailto:programs@blackaids.org)

**Bienestar, en Español**

Miércoles, 14 de Octubre del 2009, 6:00 pm

4955 West Sunset Boulevard  
Los Angeles, CA 90027

[www.bienestar.org](http://www.bienestar.org)

**Other Ways to Participate**

For those who cannot attend the Community Discussion on the 18<sup>th</sup>, or who want to contribute their comments by other means, ONAP has provided additional opportunities for input and feedback. By visiting the website, <http://www.whitehouse.gov/administration/eop/onap/action/>, stakeholders are invited to electronically submit their comments directly to ONAP.

**Introduction:**

*Relevant info about me:*

*About my community:*

*Relationship to the epidemic:*

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**My issue relates most to:**

**Outcomes**

Prevention  Care  Health Disparities  
 Cross-cutting strategies (strategies which would impact more than one of these areas)

**Process**

*or*  Creating a NHAS  
 Accountability  
 Priority Setting  
 Coordination

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**My Concern (in 10-30 words):**

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**Solving this concern requires (no more than 3 factors):**

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**Beyond funding, action on this issue also requires (3 or less factors):**

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**Who is responsible for addressing this concern (Who in the Federal government, other public and private partners?)**

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**Consequence of not addressing this concern:**

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**I will know this change has occurred when (list measurable result):**

**SAMPLE**

**Introduction:**

*Relevant info about me: I'm a gay Latino man*

*About my community: Chicago's Northwest side*

*Relationship to the epidemic: Living with HIV for 14 years*

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**My issue relates most to:**

## **Outcomes**

### **■ Prevention**

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**My Concern (in 10-30 words):**

*Young Latino gay men have no role models and suffer so much anti-gay stigma that they internalize homophobia, become depressed, and put themselves at increased risk from drug use and risky sex*

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**Solving this concern requires (no more than 3 factors):**

*(1) safe spaces and services for Latino gay youth; (2) mentoring activities that are fun, educational, and inspiring; (3) peer and mental health professionals to help counsel troubled teens*

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**Beyond funding, action on this issue also requires (3 or less factors):**

*(1) Recognition of social/cultural, peer-based services as valid HIV prevention (2) capacity development for small gay Community Based Organizations (CBOs) (3) planning and leadership to build systems and services that help teens at highest risk obtain the skills, knowledge and support (from mentors and peers) to navigate a world with HIV*

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**Who is responsible for addressing this concern (Who in the Federal government, other public and private partners?)**

*Local youth services; National Institutes of Health (NIH) to develop effective models; Centers for Disease Control and Prevention (CDC) to fund and coordinate and require public health to prioritize these models; community leaders to nurture these types of organizations*

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**Consequence of not addressing this concern:**

*Rapid growth in number of Latino gay teens and young adults who acquire HIV*

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**I will know this change has occurred when (list measurable result):**

*More gay Latino teens are in educational or mentorship programs than in the streets; when rates of Latino youth enrolling in colleges and universities increase; when the number of gay Latino programs doubles; when risk-taking by Latino youth declines; when HIV rates in this group stabilize*

## **PUTTING IT ALL TOGETHER AS TESTIMONY:**

**[INTRODUCTION:]** *I'm a gay Latino man from Chicago who has been living with HIV for 14 years.*

**[ISSUE RELATES TO:]** *I'm concerned about our country achieving better results in prevention, particularly for Latino gay youth who are a high risk for HIV/AIDS and other problems.*

**[MY CONCERN:]** *I believe anti-gay stigma hurts gay Latino youth psychologically and physically and results in many young men becoming isolated, hopeless, and ultimately turning to drugs and high-risk sex as a coping mechanism*

**[SOLUTIONS:]** *Solutions include (1) creating safe spaces and services for Latino gay youth; (2) mentoring activities that are fun, educational, and inspiring; and (3) peer and mental health professionals to help counsel troubled teens*

**[SYSTEMS CHANGES NEEDED:]** *In addition, the government must (1) Recognize that social/cultural, peer-based services are valid HIV prevention; (2) nurture the capacity of small gay Community Based Organizations; (3) and spur planning and leadership to build systems and services that help teens at highest risk obtain the skills, knowledge and support (from mentors and peers) to navigate a world with HIV*

**[RESPONSIBILITY:]** *The federal government must develop these new models, fund them, and coordinate with local public health and other entities to make sure they are prioritized through Community Planning and other mechanisms. Gay community leaders must work with government to make these vital services available*

**[CLOSING:]** *My greatest wish is that, because of the National HIV/AIDS strategy, there is renewed energy to help get gay Latinos off the streets and into supportive environments that build their confidence, knowledge, and self-esteem to pursue higher educational attainment and protect themselves. If we ignore this at-risk population, more of our gay Latino youth will acquire HIV and need more intensive services in the future*

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