We believe, and this is by sophisticated modeling, pretty sophisticated modeling at the CDC, that if we achieve the targets that we’re outlining, we could reduce new cases by 75% within five years and 90% within ten years. You know, as you get to the first 50 and 75%, it gets harder and harder to make that reduction as you move forward, so it’ll probably take us another five years to get from 75 to 90%. But, I absolutely believe we can get a 50 to 75% reduction in five years, but we have some really important leading indicators that we’re going to post and make public, transparent for everyone, so that they know probably in the first quarter of 2020, we have that on the website.

[musical interlude]

Hello, welcome, this is the January 2020 podcast of the American Journal of Public Health. In the January issue of AJPH, editors Farzana Kapadia and Stewart Landers have commissioned a set of papers discussing a commentary prepared by Admiral Brett Giroir, the Assistant Secretary of Health who is leading the public health initiative entitled Ending the HIV Epidemic: A Plan for America. Over almost 50 journal pages, researchers and public health officers and practitioners raise questions about the plan regarding stakeholders, hard-to-reach populations, stigma against LGBTQ people and people who inject drugs, the obstacles of low insurance coverage and lack of Medicaid expansion. I have, therefore, posed all of these questions to Admiral Giroir so that our authors, readers, and editors could listen to his responses directly. In his responses, Admiral Giroir mentions names of people and programs that I’m not sure all listeners will
be familiar with, so let me explain. The Secretary of the US Department of Health and Human Services, HHS, is Alex Azar. Dr. Robert Redfield, Bob Redfield, is the Director of the Center for Disease Control and Prevention, CDC. Dr. Anthony Fauci is the Director of the National Institute of Allergy and Infectious Diseases, NIAID. Rear Admiral Michael Weahkee, Mike Weahkee, is Principal Deputy Director of the Indian Health Service, HIS, and the Ryan White HIV/AIDS Program is a program which provides free or low-cost care for uninsured people living with HIV. I am Alfredo Morabia, Editor-in-Chief of AJPH and we are December 4, 2019. Thank you for being on this podcast. For our listeners, what’s your position now at HHS?

BG Yes, so I’m the Assistant Secretary for Health and I am also the Acting Commissioner of Food and Drugs.

AM Thank you. How does [it] make you relate to the plan, you know, ending the HIV Epidemic: A Plan for America? What’s your role in this plan?

BG So, my full-time job is the Assistant Secretary for Health, and in that role both myself and my office, we are the principal public health and science advisors to the Secretary. So essentially, we develop policies that sort of govern where all the operational divisions go. We write the national HIV/AIDS strategy, the viral hepatitis strategy, the physical activity guidelines, the US nutritional guidelines—that’s with US Department of Agriculture. We do so many things on the policy level with our minority health office, our women’s health office. So, an HIV/AIDS strategy is a core function of our office, so we are clearly engaged in that, and now more engaged than we have been in the past.

AM That’s terrific, and when did the idea that one could end the HIV transmission emerge? How did it start?
Well, it’s very interesting. I think as most of your listeners know, it took me about nine months to get confirmed. So, during that period of time, I spent a lot of time taking to leading public health organizations trying to fill in gaps of my knowledge. When you’re in the process, you can’t really talk to anybody at HHS because there’s a firewall. So, clearly I had taken care of children with HIV very early in the epidemic because they’d show up with pneumocystis pneumonia in my ICU or some opportunistic infection, and it was a horrible time, but I had not been involved in HIV per se as a medical or scientific avocation. But it shocked me, during my period of time that I was preparing, that I could not believe there were still approximately 40,000 new cases a year; and I felt this was shocking and alarming to me because I was under the impression, not being an expert, that we probably had good medications. I knew about PrEP. Clearly there are behavioral interventions and a whole host of things we could do, and I wondered why do we still have 40,000 cases. And that was one of the first questions I asked once I got in the system and could talk, to talk to people like Tony Fauci and Bob Redfield, and they affirmed my belief was there was no reason there were still 40,000 cases except people didn’t decide to create a program to make it go away. We had the technical capability, we have all the tools that we have lacked for the last 30 years, and so we started talking about it. Could we think about ending new HIV infections in the United States? And this was work group with Tony Fauci and Bob Redfield and myself and Mike Weahkee with the Indian Health Service and leadership at [HRSA], and we planned for several months and did very intense modeling. And I think one key insight was a very simple one. I think the CDC gets wrapped around, you know, number of—or a hundred thousand people or age-adjusted this or that, but Dr. Redfield [would] say, look, don’t worry about
all that. Let’s just do raw numbers—how many cases and where they are. And that was sort of the insight because it showed that 50% of the new cases occurred in 48 jurisdictions, 48 counties, San Juan and DC, and all of a sudden the light flashed off because we said, wow. Now it’s not a 3,000-county effort, although we want to improve all over the country, but we can focus and target public health resources, right? This is a classic public health problem that is tractable because we know where the cases are, geographically, we know who they’re affecting epidemiologically, now we have anti-retroviral therapy that anybody can take, [due to] low toxicity, U = U, and we have PrEP. Wow, we can do this. So that was the origin, we pitched it to the Secretary, the Secretary of course immediately got it, and it went right to the President who embraced it as his own and thus, our planning, you know, came about, and we all heard it publicly for the first time at the State of the Union. But that really is the short story of it.

AM Oh great, and then that’s why you say in your commentary that the time is now for ending the—

BG The time is absolutely now because number one, there’s no reason it shouldn’t be now because we’ve got everything we need. I would love to have an HIV vaccine. I would love to have a “curative” therapy. We all want that, but we don’t need a scientific miracle to occur. We can attack this problem with what we have right now. The last 30 years have been close to a medical miracle with providing us the tools that we need, so the problems are really implementation and to avoid stigma and have communication and to reach the people that haven’t been reached. That should be a tractable problem for us in our society.
So let’s look at those different points. First of all, those counties, are they located close to each other or they are spread out all over the country?

So, we have a map that is posted and will show you that, but you know they are clustered. There are four counties in Texas and there are several in California, but they are spread around the United States but they tend to localize with the major metropolitan areas. So, in addition to those 48 counties, San Juan Puerto Rico, and Washington DC, we didn’t want to just have an urban solution so we knew there were several states that had a very high rural burden of disease. So, we targeted those states too like Mississippi and like Oklahoma, and Oklahoma is a special case because of the increased incidence in the Native American population. So, one of our pilot sites, for example, we have four jumpstart sites that all got funding to really start the initiative this year, is the Cherokee Nation, primarily in the geographical space of Oklahoma.

[ musical interlude ]

So, what are the main elements of the strategy? I mean, you focus on those counties and what do you do?

So, the main elements of the strategy is number one—and this is not sort of a scientific pillar but it’s an underlying foundational principle—is that HIV is a national problem but it’s a community-by-community problem, and what works in Miami is not going to work in Jackson, Mississippi, it’s not going to work in Fort Worth, Texas. It’s not just. So the fundamental premise is we want communities to develop their own plans that involve their community-based organizations that they know of that we don’t know that understand all the nuances of the faith-based groups and the players and who does what and the community structure and the county structure. So, a fundamental principle which
we were able to fund this year is that every community needs to develop their own community elimination plan. That’s money we funded from fiscal year 19 from a minority AIDS initiative funds, and we expect all those plans due in December, and that’s why it’s so important. But built upon that, those community plans need to rely on a few foundational pillars: Number one, identify people early and get them tested. The data are horrible now about how many years on average it takes for a person to get diagnosed with HIV, and during that time their T-cell counts are deteriorating, their health is deteriorating, they’re able to pass the infection to other people. So, a key element is diagnose early, get people routinely tested; but this is really where the community is going to fit in because reaching the Latinx community in Miami is very different than reaching the rural African-American community in Mississippi, is very different from reaching the at-risk Native American community or the Alaskan natives. It really has to be a community-by-community plan, but we have tools with mobile testing and immediate diagnosis to get people in the system. The second component is get everybody on anti-retroviral therapy, linked to care as soon as possible and certainly within 30 days. When a person comes to me and I diagnose them with pneumonia, I don’t send them home and say go back six weeks from now and get your antibiotics, right? You’re diagnosed and you get treatment. So, we need to link diagnosis with treatment very closely and assure that people are retained at the treatment. And, that’s why we’re so focused on models like the Ryan White HIV/AIDS Program. They achieve a level of viral suppression, right now, about 86%, far in excess of the country’s average but dealing with people who are arguably the most vulnerable, who are poor with no other resources, with food insecurity, with housing insecurity, with no transportation, but
they’re able to overcome that—so, to put them in models of care that we know that work. That’s not the only model of care but clearly it’s one that works. Another major component is to make sure that people are as prepared as possible to prevent infection. We focus on PrEP, but you know there’s a whole other suitcase that goes with that by making sure sexually transmitted infections are all diagnosed and treated which may account for as much as 10% of HIV among MSMs. So, there are a lot of other preventive and behavioral interventions, [condoms], that need to be done, but we do focus on PrEP because we know that PrEP is, you see various standards, but Tony Fauci says at least 99% effective in preventing the acquisition of HIV. And as I think you know, we want to make sure that PrEP is available to everyone who needs it or who could benefit from it. One of our main obstacles that we felt was how do we get PrEP to those who are uninsured. If you’re on Medicaid or you have private insurance, generally—I’m not going to say overall but generally—PrEP is accessible with a reasonable copay. But if you’re uninsured, there’s nobody who’s going to be able to pay $1600 a month or $2000 a month, which is why we negotiated the donation of Truvada or Descovy from Gilead that will cover up to 200,000 who are uninsured for up to 11 years. So, this is really historic; we will be rolling this out very soon, very excited about that, so stay tuned. You don’t have to stay tuned too long, but we think this is a very exciting program, and it’s a key component. And then the final component, since you asked, the final component is to really be laser-focused on outbreak investigation. We know that there have been many outbreaks that have been associated primarily with IV drug use. Not only do we need the education and PrEP and U = U and all those things, but when there is an outbreak we have to be on that. Let me go back to Louisiana. We want to be on that like gravy on
rice, as we say. You know, we want to be all over that as soon as it happens to make sure we understand where the sources are, where the practices are so we can stop that in its tracks. Because, you could easily have 20, 50, 100, 200 cases associated, and we just can’t have that happening anymore. So those are the components, the main components, of the plan but individualized to communities.

AM So needle sharing is also part of the plan, so for those outbreaks, for example—

BG Yeah, well needle exchange not needle sharing, we don’t want people to share needles—

AM No, needle exchange I meant—

BG We definitely, whether you have my opioids hat on or my HIV hat, syringe, comprehensive syringe services programs, also known as needle exchange, are very important for a couple of reasons. Number one, clearly shown to be evidence based to prevent HIV and HCV transmission, and both of those are prime concerns, but also the data are pretty clear that people who are in a comprehensive syringe service program have a much greater likelihood of stopping IV drug use and entering long-term recovery. So, it is not only a harm reduction mechanism but it’s also a recovery and curative mechanism, at least for people to get into long-standing recovering and non-use of those drugs. So, we are firmly supportive of needle-exchange syringe services programs for both of those reasons.

[musical interlude]

AM And so, you insisted on the aspect of communities finding or building their own response. So, who would you say are the main stakeholders in this project, at the community level?

BG So, there are a lot of stakeholders and it really depends by community. You know, clearly the local health departments do have a big stake in this because, you know,
they’re involved at that level. We rely very heavily on community health centers which are really of, by, and for the community. I mean, their boards have to be made up of communities, so communities really tell them where to go, but we anticipate that in addition to Ryan White programs, community health centers will do a lot of diagnosis and treatment but also they’re going to be a primary arm for PrEP. Community-based organizations, absolutely essential, whether that’s HIV advocacy groups or people living with HIV or just the groups that are there that open community centers for people to come into to make them feel at home where they can get services they need, clearly the faith-based community. You know, we think of the faith-based communities always being, you know, antagonistic in some way, but that’s not true. I was down in Miami and there was a Catholic nun doing HIV screening on people, and that, you know, I come from a faith background, but my background is you love everyone and care for them equally because we’re all of infinite worth. So, I think fundamentally, faith-based organizations can play a really major role in destigmatizing and getting the message out. I have a last slide when I give this presentation; I say it’s a whole of society approach and [I see it as] a framework where it’s community-based organizations and the federal government and faith-based, and it’s also the commercial side, right. Gilead made a historic donation, so the commercial groups, businesses, can help with testing. But, I have a little blank spot that says your name here, because I really do mean that, is that this is doable, this is clearly doable, but it has to be a national effort where—and it’s, you know, it’s not like a NASA moon shot because it’s more like boots on the groups and communicating with people and opening arms to people and understanding how the science meets policy meets attitudes meets stigma, you know, all in this complex milieu.
But, we have seen, you know this is an important point, we have seen communities like Washington, DC and New York City and San Francisco that have had tremendous successes about bringing down new HIV infection rates by incorporating many of the things that we are going to incorporate in this program, but you know San Francisco is, again, not rural south. There are going to be issues that we have to face all through the spectrum, issues that could be non-issues in San Francisco are going to be issues in other places.

AM Yeah, and you just mentioned stigma in some states. So, what are the plans to try to reduce this challenge in the southern states in particular?

BG Well, first of all, we’re trying to walk the walk in addition to talking the talk. PACHA, the President’s Advisory [Council] on HIV/AIDS, has always met in DC and I don’t know how many meetings, 50 meetings or whatever. We sort of started a little plan, we call it PACHA to the people, that we are going and bringing leadership—myself, Tony Fauci, Bob Redfield—so we went to Jackson, Mississippi, and it was enlightening. Some of the challenges but also some of the progress they’ve made with the Open Arms clinic and community groups that are there working hand in hand now with faith-based organizations. We just in Miami because [of] a stigma in the Latin community and we hope to get to Indian country. I think talking about it and having like conservative Republicans who are in the Administration talk about this, I think it’s got to help, right, and building a very broad coalition. Secondly, we are trying to get the word out. We’re going to have major communications campaigns coming up to try to reach all the people who need to get in the system but also get a general knowledge of this. When you talk about decrease in stigma, how about the President talking about this at the State of the
Union address. So, I think when you get people who would arguably be those, that many people are surprised to be talking about the issue, talking about the issue I think that goes one step in the right direction, but clearly it’s got to be community by community, people to people, organization to organization to make this work. I wish I knew how to destigmatize substance use disorder and HIV and so many other things, but you know I think we’re reaching a point of sophistication that hopefully that stigma can go away. Because, look, we all have our issues, we all have our problems, right? This should be a non-judgmental—this is about public health and about caring for people. It’s very simple, nothing more, nothing less than that, and if we have the opportunity to eliminate a disease like HIV, like I said before no matter where you come from I think it’s our moral responsibility to do it, and that’s where we’re at.

And what is the timeline for eliminating HIV? When do you think we can—

No, we believe, and this is by sophisticated modeling, pretty sophisticated modeling at the CDC, that if we achieve the targets that we’re outlining, we could reduce new cases by 75% within five years and 90% within ten years. You know, as you get to the first 50 and 75%, it gets harder and harder to make that reduction as you move forward, so it’ll probably take us another five years to get from 75 to 90%. But, I absolutely believe we can get a 50 to 75% reduction in five years, but we have some really important leading indicators that we’re going to post and make public, transparent for everyone, so that they know probably in the first quarter of 2020, we’ll have that on the website. And I just want everybody on the podcast to understand that if we’re doing our job over the next couple of years, new diagnoses will go up, they will go up, because we have probably 100,000 people, maybe 150,000 people, living with HIV who are undiagnosed. So, what
we expect to see is new diagnosis going up but new infections going down and then over a period of time those new diagnoses will go down as well.

AM Absolutely, absolutely, and tell me is the situation easier in states that have expanded Medicaid compared to those which didn’t?

BG So, what we modeled in our program—and you don’t see a lot of it in the first year’s budget, hopefully you will see it in the second or third year budget, you know we do budgets year by year—is we did not assume that there would be any change in fundamental insurance coverage, right? We don’t control [if] the state expands Medicaid, doesn’t expand Medicaid, the degrees, but we basically took a snapshot of the status quo, and in states that did not expand Medicaid we assumed that there would need to be more resources to community health centers and the Ryan White program to cover them. So, that’s what we built into the, you know sort of the five-year projected budget. Now, if something happens, there is an expansion of Medicaid in a major state or there’s changes of eligibility, obviously we would work with that, but we just assume the base case is where we were and tried to fund around that.

AM Admiral Giroir, thank you very much, thank you for your time, thank you for this incredible plan that you are leading, and all my best.

BG Thank you so much and thanks to all your listeners. We want everybody, we want your name here, we want everybody to join this and really make it a true national movement. We will get this done. Thank you.

AM Thank you very much, take care.

[musical interlude]
Alright, by the end of this interview, the Admiral has addressed all the questions I had, even answering some of them before I had the opportunity to ask them. His answers are concrete and practical; if I may say, for a high-ranking Naval officer, Admiral Giroir has his boots firmly on the ground. I find this plan courageous. It directly addresses poverty, stigma, and discrimination in counties where it’s still too often difficult to talk about HIV, substance use disorder, or LGBTQ. The plan is using evidence-based tools such as claiming and treating, antiviral therapy, pre-exposure prophylaxis, and needle exchange. It seeks solutions for the financial obstacles due to poor insurance coverage and lack of Medicaid expansion and can apparently count on the [refunded] Ryan White program. The objective is to reduce HIV transmission by 50 to 75% in five years, and the plan will publish its results online, allowing everyone to track its success or failure. Frankly, hat’s off!

I’m grateful to Admiral Giroir for his time and his willingness to share with us his plans. I also thank Emily D’Agostino and Michael Constanza for comments and edits on an earlier version of the podcast. Francis Jacob composed and interpreted the pastiches of two famous songs associated with the history of AIDS. This is Alfredo Morabia at AJPH. For more podcasts including podcasts in Chinese, visit us at www.ajph.org or subscribe to it on your usual podcast app. A full transcript of the podcast is available on the AJPH website for persons with hearing disability. That’s it, thank you for listening!