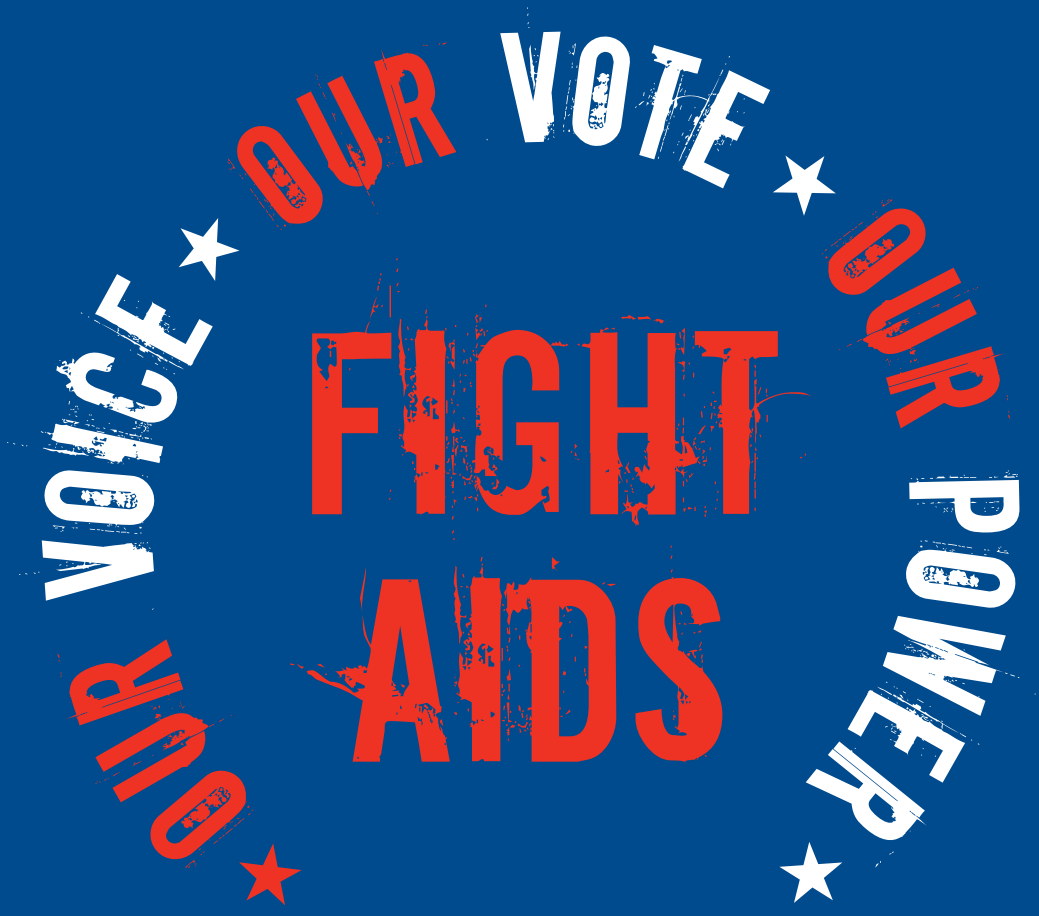
# 2009 FEDERAL POLICY AGENDA




GMHC

GAY MEN'S HEALTH CRISIS

# EXECUTIVE SUMMARY

Gay Men's Health Crisis, the world's oldest HIV/AIDS organization, has witnessed much change in the 28 years since the onset of the HIV epidemic. In 2008, voters embraced change. Changing the course of the HIV epidemic requires a renewed commitment to HIV prevention and treatment. Swift and urgent action is necessary to best address the needs of communities most affected by HIV/AIDS, given recent estimates of new HIV infections released by the Centers for Disease Control and Prevention (CDC) where the number rose to 56,300 from what was thought to be 40,000 annually.[1] The country's new leadership must push for evidence-based policies that prevent the spread of HIV and care for those already infected.

This Federal Policy Agenda is a reflection of GMHC's mission and the needs of the people we serve, as well as the communities most affected by HIV/AIDS. These 2009 public policy recommendations advocate for change in areas where there continue to be clear and demonstrated unmet needs.

## Top priorities:

- Development of a U.S. national AIDS strategy
- Repeal of the HIV immigration and travel ban
- Repeal of the federal ban on syringe exchange
- Defunding of abstinence-only-until-marriage programs
- Funding and implementation of comprehensive, age-appropriate sex education in schools
- Lifting the Food and Drug Administration (FDA) blood ban on men who have sex with men (MSM) blood donors

## Additional priorities:

- Implement prevention and research provisions targeting MSM through the President's Emergency Plan for AIDS Relief (PEPFAR)
- Pass an Employment Non-Discrimination Act inclusive of real or perceived sexual orientation and gender identity or expression
- Pass Local Law Enforcement Hate Crimes Prevention Act/Matthew Shepard Act (LLEHCPA/Matthew Shepard Act)
- Strengthen and accelerate microbicide research and development
- Increase support for HIV/AIDS vaccine research and implement provisions of the reauthorized PEPFAR to support AIDS Vaccine Development
- Pass the Early Treatment for HIV Act (ETHA) H.R. 1616
- Allow money paid to AIDS Drug Assistance Programs (ADAPs) by Medicare clients to count toward their true out-of-pocket (TrOOP) limit
- Make voluntary HIV testing a routine aspect of medical diagnostic visits
- Increase funding for prevention and treatment of anal cancer among gay men

GMHC will continue to advocate for the healthcare needs and civil rights of all people living with HIV/AIDS. The prevention of HIV transmission, access to affordable, quality healthcare, and the full realization of civil rights for all inform the following recommendations.

# TOP PRIORITIES

## National AIDS strategy

**GMHC calls for the development of a U.S. national AIDS strategy.** Such a strategy has widespread bipartisan support in Congress, and was endorsed by President Obama and Vice President Biden several times during the 2008 presidential campaign.[2] Numerous government and private studies have pointed to the need for better planning of U.S. HIV/AIDS policy and programming. For example, in 2004, the Institute of Medicine determined that federal financing of AIDS-related health care "does not allow for comprehensive and sustained access to quality HIV care" in the United States.[3]

The U.S. HIV/AIDS epidemic requires a strategic plan of action that promotes coordination across agencies, levels of government, and social sectors, accountability, evidence-based policy, and a focus on improved prevention and treatment outcomes. A key priority should be reducing striking racial disparities affecting black women and gay men, immigrants, Latinos, and Native Americans. Furthermore, the disproportionate impact of HIV on gay and bisexual men of all races (nearly three in five new infections in 2006) must be addressed.

> Over the past decade we have made significant strides in fighting AIDS in Africa and elsewhere overseas. Yet here at home the epidemic is worse than previously estimated.

The U.S. requires countries receiving assistance through the President's Emergency Plan for AIDS Relief (PEPFAR) to have a national AIDS strategy, yet since 1981 the U.S. has never had one itself. Over the past decade we have made significant strides in fighting AIDS in Africa and elsewhere overseas. Yet here at home the epidemic is worse than previously estimated. The CDC released new revised numbers reporting that 40 percent more people get HIV each year than previously known. Black women are 20 times as likely as white women to get HIV, and gay/bi men are 20 to 30 times as likely as the average person to get infected.[4] An effective national AIDS strategy would enlist faith communities, labor unions, business leaders and others in the fight against AIDS here at home.

GMHC has been actively involved in the promotion of a national AIDS strategy for two years. The past year has witnessed significant milestones in the campaign for a national AIDS strategy. In December 2007, Dr. Kevin Fenton, Director, National Center for HIV/AIDS, Viral Hepatitis,

STD, and TB Prevention, and other plenary speakers called for a national AIDS strategy at the Centers for Disease Control and Prevention (CDC) biannual HIV Prevention Conference. In May 2008, Gay Men's Health Crisis and several partner organizations hosted the first-ever Congressional briefing on the need for a national AIDS strategy. GMHC and our partners led numerous workshops at various national and international conferences to raise the issue's profile. Presidential candidates Barack Obama, John McCain, and others endorsed the call for the development of a national AIDS strategy.[5] The 2009 omnibus spending bill included $1.4 million to the White House Office of National AIDS Policy to support meeting expenses, regional consultations, six full-time staff, and communications costs to develop and oversee the implementation of a national AIDS strategy. The campaign received nationwide support; over 300 organizations endorsed the need for a national AIDS strategy. On January 21, 2009, California Representative Barbara Lee introduced H.Con.Res. 24 expressing the need for a national AIDS strategy. The resolution is currently in the House Committee on Energy and Commerce.

**The HIV entry ban undermines public health by causing immigrants already in the U.S. to delay getting tested, diagnosed and into care.**

GMHC, a leader in the Coalition for a national AIDS strategy, calls on Congress to appropriate FY2010 funding for the development of a national AIDS strategy. We also call on the Obama-Biden Administration to expeditiously appoint an advisory panel and initiate consultations with key stakeholder groups across the nation, as recommended in the framework document sent by the Coalition to the Presidential Transition Team in December 2008.[6] We are hopeful that a strong national AIDS strategy can be developed in 2009, and implemented starting in early 2010. Such a strategy is essential to reducing new infections, connecting more people to care, and ending health disparities.

## Immigration/travel entry ban

**GMHC calls for the complete end to counterproductive policies that ban HIV-positive non-citizens from entering the United States.** For the last 20 years, U.S. policy has banned HIV-positive non-citizens from entering the United States, and barred those already living here from attaining most types of legal status. The HIV entry ban undermines public health by causing immigrants already in the U.S. to delay getting tested, diagnosed and into care. The ban also causes people to disrupt treatment regimens and travel to the U.S. without their HIV medications.

Furthermore, this policy violates the human rights of immigrants and travelers as enumerated by recognized international treaties and conventions; perpetuates stigma and discrimination; and bars people living with HIV/AIDS from full civic participation. Highly skilled workers who have full health insurance through their employers cannot seek legal permanent residence in the United States if they have tested positive for HIV, unless they have an immediate family member who is an American citizen or lawful permanent resident. While opposite-sex partners can constitute such relatives, same-sex partners cannot. Thus, this policy discriminates in particular ways against gay people. Further, the ban undermines the global fight against HIV/AIDS by blocking access to treatment and returning people to countries where HIV care is limited or wholly unavailable. This complicates the already challenging regimens of HIV treatment and the development of treatment-resistant strains of HIV.

The federal government's repeal of the HIV entry ban requires two distinct and complicated processes. In 1993, the entry ban was codified in the Immigration and Nationality Act (INA). During negotiations on the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), language to remove the HIV travel and immigration ban from the INA was included in the Senate version of the bill, and later adopted by the House. On July 30, 2008, President Bush signed into law a reauthorized PEPFAR for the next five years. Congress and the President effectively removed the HIV entry ban from the INA.

The HIV entry ban provision of the PEPFAR reauthorization (Section 305 of P.L. 110-293) amends section 212(a)(1)(A)(i) of the INA so that the Department of Health and Human Services (HHS) is no longer *required* to designate HIV infection as "a communicable disease of public health significance." However HHS has not amended the original regulatory action from 1987 that came before the INA. This is the second and critically necessary step to fully repeal the HIV entry ban.

Now HHS must amend 42 CFR 34.2(b) to remove HIV infection from the list of diseases that qualify as a "communicable disease of public health significance." In the final weeks of the Bush-Cheney Administration, HHS leaders indicated that they were taking regulatory action and intended to remove HIV from the list of communicable diseases.[7] However, as of March 25, 2009, no action was reported publicly. HHS is expected to soon initiate a rulemaking process in the Federal Register, likely to be followed by a 60-day comment period. GMHC urges swift removal of HIV from the list of communicable diseases to finally end the counterproductive and discriminatory HIV travel and immigration ban.

## Syringe exchange

**GMHC calls for an end to the federal ban on syringe exchange.** Syringe exchange programs (SEPs), which allow injection drug users to trade used needles for sterile ones and which safely dispose of used needles, are a proven means of reducing HIV transmission without increasing rates of drug use.[8] Their effectiveness has been borne out by study after study throughout the epidemic. There are currently an estimated 185 syringe exchange programs (SEPs) operating in 36 states, the District of Columbia, and Puerto Rico.[9]

SEPs, in addition to reducing the spread of HIV, offer or connect individuals to services that further protect and educate injection drug users. Nearly all SEPs provide alcohol pads, male condoms, and referrals to substance-abuse treatment. Some SEPs also offer onsite medical care, counseling and testing for HIV and hepatitis C, and certain vaccinations.[10]

Injection drug users using SEPs have been shown in studies to be less likely to utilize local emergency rooms.[11] They are more likely to enter into detoxification programs and cease the dangerous practice of syringe-sharing.[12] HIV infection rates in communities with SEPs in place have shown overwhelming declines (for example, a 78% decline in reported HIV infections among intravenous drug users in New York State since 2000).[13] SEPs do not increase drug use, crime, or inappropriate discarding of needles.

Since 1988, however, there has been a federal ban in place on funding these programs.

In 2007, Congress and President Bush effected a repeal of the law restricting the District of Columbia's ability to use local funds for syringe exchange. President Obama and Vice President Biden endorsed syringe exchange during the 2008 campaign.[14] The logical next step, particularly under an Administration and Congress committed to science over ideology, is repeal of the federal funds ban. This could be accomplished by removing restrictive language from the labor/HHS appropriations bill.

On January 6, 2009, Congressman Jose Serrano (D-NY) introduced the Community AIDS and Hepatitis Prevention (CAHP) Act (H.R. 179) which would lift the ban on federal funds being used for syringe exchange. **GMHC calls for swift passage of H.R. 179.**

## Sexuality education

**GMHC calls for the full defunding of abstinence-only-until-marriage programs.**

Abstinence-only-until-marriage programs, currently receiving approximately $300 million a year in federal and state funds, are counterproductive and harmful to America's youth.

The sexual health of young Americans has declined significantly over the past decade. Rates of sexually transmitted infections (STIs), unwanted pregnancy, and HIV are up for young men and women in New York and nationwide. In New York City, new HIV infections are up among females 13–19 and gay and bisexual males 13–29.[15] Four million American adolescents get a sexually transmitted infection each year. One in four teenage females has an STI, as does one in two black teenage females.[16] Teen pregnancy is on the rise for the first time since the early 1990s.[17] Forty-eight percent of high school students report being sexually active.[18]

> Abstinence-only programs promote regressive, sexist gender stereotypes; spread dangerous misinformation about the efficacy of contraception and how to prevent HIV infection; and demonstrate pervasive anti-gay bias and ignorance about people living with AIDS.

Abstinence-only-until-marriage programs have been unable to demonstrate behavioral outcomes. The U.S. Department of Health and Human Services commissioned an April 2007 study that found these programs to be ineffective in increasing teen rates of sexual abstinence. It found that more than half of the youth became sexually active before marriage regardless of whether they had taken a "virginity pledge."[19] Following a comprehensive review of programs, the National Campaign to Prevent Teen and Unplanned Pregnancy reached the same conclusion.[20] Youth undergoing abstinence-only-until-marriage "education" have shown no significant differences in rates of pregnancy or sexually transmitted infections.[21] Abstinence-only programs often involve the taking of "virginity pledges." Youth in communities where high numbers of students have taken "virginity pledges" are less likely than students in other communities to use contraception, have similar rates of STIs than those in other settings, and are less likely to seek medical attention in relation to a suspected sexually transmitted infection.[22]

> One in four teenage girls in America has a sexually transmitted infection.

Abstinence-only programs promote regressive, sexist gender stereotypes; spread dangerous misinformation about the efficacy of contraception and how to prevent HIV infection; and demonstrate pervasive anti-gay bias and ignorance about people living with AIDS. As such, they are not only ineffective and a waste of public dollars; they are also harmful to young people.

Twenty-five states have taken a strong stance against the approach's biased and dangerous tactics by not accepting federal dollars for abstinence-only-until-marriage programs.[23,24] They join thousands of health and medical professionals in concluding that abstinence-only-until-marriage is a public policy failure. President Obama was one of only three candidates running for president to support an end to federal funding for abstinence-only-until-marriage.[25] GMHC looks forward to working with the Obama-Biden Administration and the 111th Congress to end funding for failed, ideological approaches to sex education and shift such funding to proven, scientific methods.

**GMHC calls for comprehensive sex education as the most effective protection for young people against disease and unwanted pregnancy.**

Young people are more likely to become infected with HIV by having sex than any other method.[26] *The Washington Post* reports that after a steady decrease in reported teenage sex since the 1990s, the CDC's Youth Risk Behavior Survey (YRBS) reported no change since 2001 among all races and ethnic groups.[27] In fact, YRBS reports that almost half (48%) of all high school students reported having sex in 2007.[28] However, close to one-fifth (18%) of sexually active youth reported not using prevention methods for STIs or pregnancy the first time they had sex. African-American and Latino students report having more sex than their white peers. They also report their first sexual experience at a younger age, with 16% of African-American and 8% of Latino students initiating sex before the age of 13, compared to 4% of their white peers.[30] Nearly a quarter of high school students that have sex reported drinking alcohol or using drugs the last time they had sex, impairing their ability to make safer sex decisions.[31] A recent national study found that one in four girls ages 14 to 19 have at least one common STI, and nearly half of African-American girls surveyed were infected with an STI.[32] In spite of these figures, the CDC found that only 16% of young adults reported testing for HIV in 2006.[33]

Comprehensive programs about sexuality—medically accurate, age-appropriate education that includes information about both abstinence *and* contraception—have been found to be effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use among teenagers.[34, 35, 36] Comprehensive sex education has the support of leading public health institutions including the American Psychological Association, the American Medical Association, the National Association of School Psychologists, the American Academy of Pediatrics, the American Public Health Association, the Society for Adolescent Medicine, and the American College Health Association.

## Food and Drug Administration (FDA) blood ban

**GMHC calls for an end to the unjustifiable ban on MSM blood donors.** Much of today's medical care depends on a steady supply of blood from healthy donors. Despite shortages in the nation's blood banks, the Food and Drug Administration (FDA) continues to adhere to its ban on male donors who have sex with men. Under FDA guidelines, a man who has had sex with another man (MSM), even once, since 1977 is ineligible to *ever* donate blood.

The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have filed a petition to the FDA to repeal its prohibition on MSM as blood donors.

The ban on MSM blood donors is a holdover from a time when panic and discrimination drove health policy. In the more than two decades since the ban was enacted, scientific knowledge on blood screening and assuring the safety of transfusions has grown significantly. Thirteen tests (11 for infectious diseases) are performed on each unit of donated blood; these tests include screening for Human Immunodeficiency Virus (HIV).[37] In April 2008, Representative Sam Farr from California called on the FDA to reassess this discriminatory policy, adding that, "the science doesn't seem to support that policy decision."[38] The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have asked the FDA to reduce the lifetime prohibition on MSM as blood donors to a 12-month deferral.

The cost of discrimination is high. Blood supplies reach dangerous lows when less than 5% of healthy Americans eligible to donate blood actually do so. In 2007, the blood supply was at a five-year low in New York. In California, officials in one school district have recently indicated that they may end blood drives in city schools if students are compelled to disclose information about their sexual activity. Forcing students to "come out" as gay or bisexual, threatens their emotional and physical well being at school, compromising their safety and thus their ability to achieve success. This policy stigmatizes gay men and other MSM as well, but individuals who need blood pay the greatest price.

# ADDITIONAL PRIORITIES

## President's Emergency Plan for AIDS Relief (PEPFAR)

**GMHC calls for continued focus on prevention and research targeting MSM through the President's Emergency Plan for AIDS Relief.** The reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), passed and signed into law in July 2008, calls for HIV prevention designed for MSM, as well as research to better understand HIV among MSM in the global epidemic. This is especially important in Africa and the Caribbean, where homosexuality is largely underground and little epidemiological research exists. International and local experts agree: understanding and addressing the needs of men who have sex with men are key to ending the AIDS crisis.

GMHC applauds the inclusion of language calling for prevention programs for MSM and research on HIV among MSM in the HIV/AIDS epidemic. We urge the Obama-Biden Administration, Secretary of State Clinton, and others to implement these provisions and channel funding toward groups working to prevent HIV among MSM around the world.

African leaders support more HIV prevention targeted toward MSM and research on the extent of the epidemic among MSM. At the United Nations High-level Meeting on AIDS in June 2008, African political and public health leaders released a report calling for prevention among MSM and "good surveillance data and better monitoring" so that resources are "spent where they will do the most good."[39] The report, *Securing Our Future: Report of the Commission on HIV/AIDS and Governance in Africa*, was co-chaired by Kenneth Kaunda, former President of Zambia and Pascoal Mocumbi, former Prime Minister of Mozambique (both PEPFAR recipient countries). It cites studies indicating that sex between men "could be an important factor in several of the epidemics in this region, despite the widely-held assumption that sex between men is 'alien' to African societies."[40] The Commission report describes how stigma and discrimination help perpetuate the epidemic, then calls for protecting human rights, "promoting safer sexual behavior among these groups and their partners," and "implementing policies and legal frameworks that do not criminalize and discriminate against the target groups."[41] It concludes:

> There is a clear need for further research on this aspect of the HIV epidemics in sub Saharan Africa, and for prevention efforts that focus on averting HIV transmission among men who have sex with men and their female partners.[42]

In its 2008 *World Disasters Report*, the International Federation of Red Cross and Red Crescent Societies reports that HIV/AIDS is a disaster not only for the countries hardest hit, but also for men who have sex with men wherever they live. A recent review of evidence from 39 low- and middle-income countries found that, on average, the HIV prevalence rate among MSM is 12.8 times the rate among the whole adult population, and prevention services for MSM currently reach only 9 % of that group. Markku Niskala, Secretary General for the Federation, writes that these men "have the same human rights as everyone else, the same right to healthcare and protection from disease."[43]

Current HIV prevention efforts are not effective in reaching MSM, to the detriment of both men and women. Research with MSM in Kenya and Ghana demonstrated that MSM do not consider themselves at risk of contracting HIV, because all of the prevention messages thus far have focused on heterosexual couples.[44, 45] Doctors in Uganda and Togo report similar anecdotal findings. Many MSM also have sex with women, thus contributing to the risk women face.[46, 47]

Social and epidemiological research on MSM infected and affected by HIV in Africa is necessary to move forward in combating the epidemic. There is a dearth of research on HIV and same-sex behavior in African nations. Many researchers, whether publicly or privately funded, do not inquire about same-sex practices for many reasons, ranging from personal bias to fear about safety where persecution of perceived homosexuals is state-sanctioned.[48] U.S. support via PEPFAR for research on this issue will not only delineate the needs and health concerns of this vulnerable segment of the population, but also encourage African governments to confront the HIV challenge from all fronts.[49, 50]

## Stop employment discrimination

**GMHC calls for passage of an Employment Non-Discrimination Act which would prohibit workplace discrimination based on real or perceived sexual orientation and gender identity or expression.** In 30 states it remains legal to reject or fire someone simply based on their sexual orientation, and in 37 states someone can be fired based on their gender identity or expression.[51] A strong majority of the American public supports sexual orientation nondiscrimination laws, including a majority of Republicans.[52] Nearly 9 in 10 Americans support the principle of equal treatment at work regardless of sexual orientation.[53] Congresswoman Bella Abzug of New York introduced the first federal sexual orientation nondiscrimination law in 1975. Thirty-four years later, it's time Congress passed such a law.

## Microbicides

**GMHC calls for support to strengthen and accelerate microbicide research and development.** AIDS is now the number one cause of death in the United States among African American women aged 25–34. One of the most promising prevention tools is microbicides. Microbicides, both vaginal and rectal, are a new class of topical product—in the form of gel, cream, film, vaginal ring, or suppository—that could significantly reduce the risk of transmission of HIV and other sexually transmitted infections.

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Scientists estimate that a safe and effective microbicide could be available within five to seven years and that the impact would be considerable. Mathematical models predict that even a partially effective microbicide could avert 2.5 million new HIV infections in women, men, and children worldwide over three years.

## Combat hate crimes

**GMHC supports passage of Local Law Enforcement Hate Crimes Prevention Act/Matthew Shepard Act (LLEHCPA/Matthew Shepard Act)** to give local law enforcement the necessary tools to deal with violent, bias-motivated crimes. It would also facilitate federal action when local authorities are unable or unwilling to take action. The bill would expand hate crimes statutes to include violent acts perpetrated based on race, color, religion, national origin, sexual orientation, physical disability or gender identity or expression.

## Vaccines

**GMHC calls for increased support for HIV/AIDS vaccine research.** HIV/AIDS vaccine research is not being supported as it should by the private sector. Only 10% of funding for HIV/AIDS vaccine research and development comes from the large pharmaceutical and biotech companies that possess the unique expertise in innovation, product development, and manufacturing that is sorely needed.

**GMHC calls for the implementation of provisions of the reauthorized PEPFAR to support AIDS vaccine development through advanced market commitments or other incentives,** for the private sector to invest in the research and development of vaccines against infectious diseases. These include HIV/AIDS as well as tuberculosis, pneumonia, malaria, and others. Such diseases kill 11 million people per year worldwide, most in resource-poor nations.

## Early Treatment for HIV Act (ETHA)

**GMHC strongly endorses passage of the Early Treatment for HIV Act (ETHA) H.R. 1616.** Passage would allow states to amend their Medicaid eligibility requirements to include uninsured, asymptomatic low-income people living with HIV. Studies have shown that implementing ETHA could reduce the death rate for people living with HIV/AIDS by as much as 60% and slow disease progression.[55]

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## AIDS Drugs Assistance Programs (ADAP) as True Out Of Pocket (TrOOP) costs

**GMHC strongly recommends that the money paid to ADAPs by Medicare Clients count toward their true out-of-pocket (TrOOP) limit.** Doing so will give needy individuals access to Medicare catastrophic coverage and free ADAPs to help other individuals in need. Additionally, Medicare beneficiaries with HIV/AIDS would have better access to the host of medications they need to treat co-occurring conditions and side-effects from their HIV treatment.

## Testing

**GMHC supports making voluntary HIV testing a routine aspect of medical diagnostic visits.** HIV testing will help prevent the spread of HIV throughout the United States by reducing the number of Americans who spread the virus unknowingly. Approximately half of all new HIV infections are caused by people who are unaware of their HIV status and who have been infected themselves for less than two years.[56]

**GMHC urges support for efforts to increase access to voluntary HIV testing and counseling and to remove any barriers to testing utilization.** Such efforts include making HIV testing and counseling a routine component of medical care. Routine offering of HIV testing in diagnostic settings should include the dissemination of critical information and pre- and post-test counseling so patients can make voluntary informed decisions upon taking an HIV test.

## Anal Cancer among Gay Men

**GMHC supports increased funding for prevention and treatment of anal cancer among gay men.** Anal cancer is generally rare in the U.S. With a total of 4,650 cases per year, the rates of anal cancer in the general public averages two cases per 100,000.[57] However, among MSM, the rates are 35/100,000 for HIV-negative MSM, and 80/100,000 for HIV-positive MSM.[58] Gay men are 20 times more likely than the general population to get anal cancer,[59] and HIV-positive men who have sex with men are up to 40 times more likely than the general population to develop anal cancer.[60] Both anal cancer and cervical cancer are caused by strains of the human papilloma virus (HPV). The rates of cervical cancer used to be about 35/100,000 before pap smears, and dropped to 4/100,000 once pap smears became routine. Anal pap smears should also be made widely available to men. The FDA approved Gardasil as a vaccine against HPV in girls and women age 9 through 26. **GMHC urges the FDA to trial and, if appropriate, approve Gardasil for use with boys and men to reduce anal cancer rates among gay men.**

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## About Gay Men's Health Crisis

**Our Mission:** GMHC fights to end the AIDS epidemic and uplift the lives of all affected.

**Our Clients, Our Services:** Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. GMHC serves one in every six persons diagnosed with AIDS in New York City. As the world's oldest AIDS service provider, GMHC helps over 15,000 men, women and children and their families each year. GMHC offers a wide range of comprehensive client services, including hot meals, benefits/entitlements advocacy, healthcare advocacy, case management, legal assistance, HIV counseling and testing, individual and group counseling services, prevention education, home-based support, and mental health services.

GMHC has been on the frontlines of the AIDS epidemic since it began, focused on the communities most threatened by HIV and expanding our service provision as the epidemic shifts and grows. The number of GMHC clients has increased by over 50% just since 2000. Our clients reflect the diversity of the HIV epidemic:

- 67% are people of color;
- 65% are gay, lesbian, bisexual;
- 23% are women; and
- Over 50% reside outside of Manhattan.

Additionally, approximately 27% of our clients are 50 years of age or older, while 19% of all new prevention clients are under 30. Of our total clients served we continue to see a larger proportion living in poverty – approximately 78% are living on an annual income of less than $10,000, while 8% are either homeless or living in transitional housing. Over 70% of GMHC clients rely on Medicaid, while 15% rely on the AIDS Drug Assistance Program (ADAP) for their medical care and life-saving prescription drugs.

*Questions? Contact Nathan Schaefer, Director, Public Policy, at (212) 367-1041.*

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