Coming Together for Sexual Health Podcast

Monica Gandhi, MD: HIV as a Movement, Not Just an Infection

Tammy Kremer:

Welcome to Coming Together for Sexual Health. I'm Tammy Kremer and I'm thrilled to talk with you about the world we are creating by coming together for sexual health. And yes, the pun is intended. My background and thinking holistically about health as a facilitator and a doula helps me talk with our guests about celebrating pleasure, combating stigma, and making sexual healthcare both more accessible and more inclusive of the communities we serve. We're powered by nationally recognized experts in sexual health at the University of California San Francisco, and the California Prevention Training Center. All views expressed are those of the person speaking and not of the CAPTC or their employer. Subscribe to get our latest episodes, share with your friends, and leave us a five-star review to help more people find us. Thank you for coming together for sexual health. Just a note, Dr. Gandhi and I are recording this in December 2024.

Welcome to Coming together for Sexual Health. Dr. Monica Gandhi, I am so excited to speak with you. You are such a big important voice both on HIV and on Covid, so I'm just thrilled that I get to talk with you today.

Dr. Monica Gandhi:

Thank you so much. That's very nice of you.

Tammy Kremer:

Yes. So Monica Gandhi, MD MPH is a professor of medicine and Associate Chief in the Division of HIV, Infectious Diseases and Global Medicine at the University of California San Francisco. She's the director of the UCSF Center for AIDS Research or CFAR, and the medical director of the HIV clinic or Ward 86, at San Francisco General Hospital. She also serves as the Associate Program Director of the Infectious Diseases Fellowship at UCSF. Her research focuses on HIV treatment and prevention optimization, HIV in women, adherence measurements in HIV and TB, adherence interventions, and on optimizing the use of long-acting antiretroviral therapy or ART, which is something we'll be talking about today. So I'm really excited to get into this conversation. I feel like there's a million different conversations we could have, but for today we're going to focus on biomedical HIV treatment and prevention options. And if we have time, maybe we can get into some other details. To start us off, you've been at Ward 86 since the '90s, is that right?

Dr. Monica Gandhi:

I came in 1996 to UCSF as an intern, and I came from Harvard for medical school. And the reason I wanted to do my internship residency here so badly is because I wanted to be in the epicenter of the HIV epidemic. This is really a place where a lot of cutting-edge research is done. Highly active oral antiretroviral therapies were just becoming available. Three years later in 1999, I started my infectious

disease fellowship at UCSF and I've been on faculty ever since, since 2003. I was first at Parnassus, but then I went down to Ward 86 in 2008 and then it's my privilege after admiring Ward 86 for so long to become the Medical Director of Ward 86 in 2014. And I'm now the director of the Center for AIDS Research, which is sort of an umbrella organization that combines all of our research across UCSF and the other affiliates of UCSF putting us all together to talk about our research.

Tammy Kremer:

Such a rich history and relationship to this work. I just recently read and then watched And the Band Played On for the first time. And it was just so amazing to kind of get the play by play, at least from one person's perspective, of how the early epidemic unfolded. And it just gave me such an appreciation for the kind of work that you and others are doing, and also left me with so many questions about why is it that the treatment and prevention options we have are what they are and what makes it so hard to really treat or prevent HIV with a vaccine and come up with a cure. And so I thought it would be interesting if we could start by talking a bit about the mechanism of HIV in the body, how it functions, and how it infects cells.

Dr. Monica Gandhi:

So HIV is a retrovirus, and what that means is that each genetic material is RNA, but then it gets into your human body and then its genetic material changes by a process called reverse transcription to DNA, which is of course our genetic material. And then the DNA of the HIV virus goes and integrates itself into the host cell chromosome so that you as someone living with HIV, really have that viral DNA integrated into your host DNA, which makes it extremely difficult to cure. And in terms of vaccine, the vaccine issue is that we usually rely on the immune system when we are giving someone a vaccine, what we're trying to do is generate immune responses to prevent that virus from taking hold in us. But of course, the HIV virus affects the very system, the immune system by which we're trying to combat its uptake.

And so the fact that the virus is very clever and it goes for the immune system, it affects what are called CD4 cells, which really help us fight viruses and fungi and parasites and bacteria. So the fact that it targets the immune system and that it gets knitted into your host cell DNA is what has made it so difficult to yet get to cure and vaccine. We're hoping, we're still working on it, there's still a lot of exciting research, a lot of it being done at UCSF for cure. And there's also seven people who have been cured in the universe of HIV, so that gives us hope that we will be able to get there, but we're not there yet. On the other hand, treatment and prevention, amazing. We have lots of options.

Tammy Kremer:

So for the folks that have been cured, were they cured using similar mechanisms or different mechanisms?

Dr. Monica Gandhi:

Yeah. The way that these seven people were cured essentially is that when HIV enters the human cell, it enters through a cellular receptor called CD4, and it also needs a helper receptor to get in. It's called CCR5. And there are some people born in this planet who do not have a CCR5 receptor at all. And that actually probably was protective against smallpox a long time ago, but it just means that those individuals can never be infected with HIV. So these seven people who were cured, they actually all needed a bone marrow or a stem cell transplant for something else like leukemia or lymphoma. Before you give someone a bone marrow transplant, you wipe out the diseased cells and you wipe out their

own immune system, then you give them back cells from a donor. Those cells that they gave them back from a donor didn't have the CCR5 receptor on it basically.

So then when the HIV was trying to run around and find a place to set up shop with the new white blood cells, they simply couldn't. And those individuals look like they've been cured. So it does give us hope that could we do gene editing or CRISPR technology or somehow take out that gene that codes for that particular receptor in the future? And all of these approaches are being explored, including broadly neutralizing antibodies, immunotherapy. There is a lot of research going on in cure, and Steve Deeks and his group here at UCSF are really leading the way with cure initiatives.

Tammy Kremer:

Thanks for explaining that. That's pretty amazing just to think about the different modes of responding to or interacting with the way that the HIV virus itself is built. So can you talk a bit about treatments at this point and how they interact with the HIV virus?

Dr. Monica Gandhi:

Yeah. So when we first heard about HIV, it was June 5th, 1981, and it just was really a day that kind of stays in our mind forever because it was a day where these case reports came out in the CDC MMWR of these terrible infections that were occurring mainly in gay men in Philadelphia, Miami, LA, San Francisco, New York. And these were really showing us this terrible, didn't know what it was, illness that was making generally, again, young gay men in this country, very sick, and they were getting infections that we hadn't seen before except if you had had a transplant or really were immunocompromised. And it took a bit, and again, I do think UCSF big player in that, to identify the virus. Jay Levy was our UCSF lab-based researcher who helped identify the virus, figured out that it was a virus and it was a retrovirus, but there was no treatment.

And so if it was described in 1981, even though we had some not great treatments for a while, it really wasn't until 1996 that we got what are called highly active antiretroviral treatment. And what those treatments were were a combination of usually three different pills that you would have to take in lots of times a day, but that oral antiretroviral therapy changed the morbidity and mortality curve of HIV immediately. I was an intern in 1996 at UCSF, and the first half of my year was basically holding men's hands at San Francisco General as they were dying, and the second half of my year was just watching people rise from the dead, and it was amazing.

Tammy Kremer:

Wow.

Dr. Monica Gandhi:

They are miraculous HIV medications. However, they weren't always easy to take. And actually it took quite a long time to get away from those handfuls of pills, multiple drugs a day, lots of toxicities, lots of adverse effects, lots of gastrointestinal symptoms, nausea, vomiting, rash, lots of things that happened with these handfuls of pills to get down to a more streamlined way to treat HIV. And we're now at a time in history where we have one pill once a day. The one pill has three pills in it. You just have to take one pill once a day and you can have a normal lifespan, absolutely live well with HIV. And it's really just been such a honor to be in HIV medicine all my life and see this transformation.

Tammy Kremer:

It's really striking to think too about that difference of thinking 1981 all the way to 1996. What do we know about the outcomes that people were experiencing before ART?

Dr. Monica Gandhi:

I think all of us, especially those who were here because we were the epicenter of the epidemic in San Francisco in the United States, knows one or more completely tragic deaths. They were awful. It was terrible. It was just helping people die with dignity because people were dying of what's called PCP pneumonia, which is a terrible lung infection that can occur in AIDS patients. Cryptococcus meningitis, which is a fungal infection that gets into the brain. Kaposi sarcoma, which are the purplish spots but also could get into your lungs and your gastrointestinal tract. CMV retinitis, so going blind from unfortunately a very common viral infection. Lymphomas, just terrible, terrible etiologies, and it was a very hard time to be an HIV doctor. Again, I started in 1996. I was very lucky to start when the oral antiretroviral therapies were available, but many who came before me who started Ward 86, it really was just helping people have dignity as these terrible deaths were occurring.

I will also say that because I work at San Francisco General and because I work with a population that is publicly insured and has had a lot of concomitant challenges, there are still people who are having these terrible opportunistic infections they're called and are being hospitalized at San Francisco General with everything I just said. I was just on clinical service at San Francisco General, and every single one of those diagnoses I just said I saw last week here in the city.

Tammy Kremer:

Wow.

Dr. Monica Gandhi:

And the reason I saw it is because in this city, the urban problems that make it difficult to take HIV medications are really housing insecurity, substance use, and mental health concerns. And you put those three together and it's very hard to take a pill, one pill once a day. So when we say one pill once a day, absolutely is a miracle and amazing for the majority of people living with HIV, but there's about 10% of the population here in the United States that that is not working for them. It is too hard when you are really fighting for subsistence to take one pill once a day. And we do need not only other options for them, but we need really patient care and I mean really engaged care with that population so that we don't have these opportunistic infections that I saw in 1996, and I'm seeing again in 2024 at the same hospital where I trained.

Tammy Kremer:

That's so sobering to really understand that is happening today and underscores what I've learned a bit about, in terms of the work you've done along acting injectables for HIV, how's that been rolling out and how is that looking in terms of those same folks?

Dr. Monica Gandhi:

So 1996, we talked about the medications getting better and better, one pill once a day, but we still needed something else. And in 2021 we got what are called long-acting antiretroviral therapy, which is really just the combination of two medications, one's called Cabotegravir, which is what's called an integrase inhibitor. The other one's called Rilpivirin, which is a non-nucleoside reverse transcriptase inhibitor. And those two injections were given, they're given in the gluteal muscle, and they're given either once a month or once every two months, and they had been studied before they were released in

2021 in kind of perfect patients, patients who could take the oral therapy, you're doing great, and then you switched over to injectable because you were in a study, but you really had no problems taking the oral ART. And that's how they were approved. You had to be able to take oral antiretroviral therapy.

But then we looked at our population at Ward 86, a third of which, a full third has marginal housing in the city. And we said, "Well, I know it's not approved for patients who have marginal housing and problems with taking pills every day," and importantly, viremia where their virus isn't suppressed because the goal of HIV therapy is to get your virus suppressed all the way, but we wanted to try these long-acting antiretroviral therapies in those patient populations that had all these adherence challenges because it's that patient population that is on the edge of getting really sick or already very sick or having opportunistic infections, and we wanted to take HIV out of their concern list and they could then focus on housing and everything else. So we started using the long acting antiretrovirals very soon after approval. In patients with viremia, they had high rates of substance use.

We did a study where there was at least a 34% rate of methamphetamine and cocaine use. They had high rates of housing insecurity, 68% in our cohort, and they had high rates of mental health diagnoses, anxiety, depression, or psychotic disorders, over a third. And we used the long-acting antiretroviral therapy in them. And I remember someone saying to me, "Do not do this. You're going to cause drug resistance. You are going to get in trouble." And we did it, and it wasn't just me, it was my clinic. It was just the amazing nurses and social workers, specifically our nurse director Jan Oskerson, who I think just made this entire thing happen. He got nurses to just figure out how to give the injections quickly so people didn't have to wait. They're just coming in and out, getting the injections, going out the door. They don't have to worry about it for two months, then come back, get your injections.

The other thing that people said to me is, "If you give someone who is adherence challenged long-acting injectables, they're not going to come back for their next injectable." And you know what happened is that people were so relieved to be virologically suppressed for the first time, to have this just taken off their problem list when they had so many other things going on, that they are very motivated to come back, have an internal motivation, and we're calling them to come back, but they come back. And we now have presented data in different forms, including peer-reviewed publications, that these long-acting antiretroviral therapies are working beautifully in those with viremia where their virus isn't suppressed, in those with all these other incompetent social challenges, and then really gratified to say that the main guidelines committee in the United States, which is called the DHHS Committee, Department of Health and Human Services, they just changed their guidelines on September 12th, citing our data at Ward 86 to say, "If people are at high risk for progression and they really can't take oral ART, this data is enough to say, 'Okay, let's do it. Let's try it in those who are viremic and otherwise are going to get really sick.'"

And with that guideline change, I think that does open up every provider in the United States to use them. Just cut out that paragraph from the guideline, send it to that [inaudible 00:16:55] insurance company and say it's been recommended.

Tammy Kremer:

Wow. That is a truly major contribution to have had the research really move policy forward that way so concretely.

Dr. Monica Gandhi:

Yeah, thank you.

Tammy Kremer:

I volunteer with the Shanti Project, which is a local San Francisco based organization which has been involved in caring for folks with HIV as well as other folks in San Francisco since the mid '70s, but has done a lot with HIV AIDS patients. And I was there when you were awarded for the service that you've done for the community.

Dr. Monica Gandhi:

Thank you. That's a great organization. Shanti really helps people not be alone when they're suffering or struggling, so it's such an important organization.

Tammy Kremer:

Yeah. When someone has already progressed to a level with HIV where they're having some of those conditions you mentioned earlier that you've seen in the clinic in the last week or two, is something like ART going to help them at that point or is it too late for that? And if someone is kind of in between doses or they get some level of dosage, does it decrease possible symptoms or does it not impact at all?

Dr. Monica Gandhi:

Those are great questions. ART, even if you are on literally the brink of death with opportunistic infections, will absolutely help you and will absolutely bring you back. I really can't tell you how much I have seen over my 25 years of treating HIV, I have seen very, very ill individuals do great absolute return to health, go back to the workforce, just absolutely fine. Had babies, because I used to treat a lot of women. I started out with treating only HIV infection in women. I have seen women who started out very sick and are absolutely fine, able to bear children and have healthy children who are born without HIV. So when I said miracles, these are miracles. Now, there are just a couple of things that are maybe not reversible. Unfortunately, there is a terrible brain infection called PML, which is caused by a virus, and we aren't able to always reverse that with the HIV therapies.

And then sometimes if there's been damage that it's just too late, then some of those residuals will stay. So for example, I have a patient who had CMV retinitis a long time ago, doing great now, but she still has a lot of vision loss. But in general, again, they are really incredible drugs. The point of treatment is to get to virologic suppression. What that means is that the virus gets into your system, it infects these cells that have CD4 cell receptors and it makes a lot of baby viruses and it gives you a very high, what's called HIV viral load, lots of replication of virus in your body. The goal of therapy is to get that viral replication down so that by our current assays, we can't even find it. We call that undetectable. We call the viral load being undetectable the goal of therapy. And we used to, when we didn't have a lot of options, let people hang out at a viral load of 1,000 or 2,000 or 5,000 because we just didn't have a lot of options.

But we have so many more HIV medications now of different classes that there's no goal in between. Our goal is to get everyone on this planet virologically suppressed. Is everyone on this planet virologically suppressed? No. So the UN AIDS statistics in July showed that of the people living with HIV in the world, which is over 40 million, 72% are virologically suppressed, so have a way to go. And then in the United States, it actually depends on your clinical setting. Overall, the rates of virologic suppression are not as great as we thought they'd be in 2024. They're about 70%, but they're much higher in places that have wraparound care. And this is my plug for the Ryan White CARE Program, which was formed in 1990. Cannot tell you how important this bi-partisan program is that provides wraparound care for those who are living in poverty with HIV. And by wraparound, I mean case managers, social workers, pharmacy support onsite, something where you just go to one place, get all your care.

The Ryan White CARE program has enabled people who are poor living with HIV in this country to actually be doing even better than some of these privately funded clinics because they have all those

services to help them. So it is a new administration. It is a uncertain time. I just have to say, please keep on funding Ryan White, keep on funding. And the HIV Epidemic Initiative, which was formed under the first Trump administration, now we're going into the second, so let's keep that going. And the HIV Epidemic means treat everyone with HIV, prevent HIV, diagnose everyone with HIV, and stop outbreaks. Please continue funding NIAID and the NIH at high levels for infectious disease research. I know there's polarization. I know it's been a hard time. I did a lot of Covid. I get it. It is essential to keep our gains in HIV.

Tammy Kremer:

Yeah, the stakes are really high right now. We are in fact also funded by Ending the Epidemic money in part at the California Prevention Training Center. Not our whole team, but we're very directly a part of that because we provide training to organizations that are funded by that money. So we're keeping our eye on that.

Dr. Monica Gandhi:

Such an important initiative. And to give credit, PEPFAR was formed under G.W. Bush, Republican President, and Ending the HIV Epidemic was formed under President Trump first administration. So we got to remember that HIV in general was always kind of a bipartisan support for it. So let's keep the bipartisan support and maybe fight about other stuff.

Tammy Kremer:

Yeah, let's keep it that way. Yes. Well, as you were describing the Ryan White program and wraparound services, you mentioned a few different issues around access. I know one of the conversations around long-acting injectables is around access, like you mentioned insurance issues. Who are you thinking about that you want to make sure this new way of treating will reach and what concerns do you have about what might get in the way of that?

Dr. Monica Gandhi:

It's so terrible in terms of the questions of access because the reason I use the word terrible is back in 2001, when oral antiretroviral therapy was available in Europe and the US, it just wasn't available in the high burden countries, which was, for example, Eastern and Southern Africa. And that discrepancy was so hard to see and was so fought by the HIV community. The International AIDS meeting was held in Durban in the year 2000, and there were big protests with men and women from this country holding up signs saying, "I'm not going to take my HIV therapy unless my brothers and sisters here in South Africa can get their HIV therapy."

Tammy Kremer:

Wow.

Dr. Monica Gandhi:

And that discrepancy did partially get resolved from that landmark PEPFAR program. President's Emergency Plan For AIDS Relief formed under G.W. Bush in late 2003, early 2004. So again, Republican administration. So it is just amazing the impact that PEPFAR has had on access to oral antiretroviral therapy worldwide. I think they're really responsible for 25 million people being on therapy.

Where we are right now is back to 2001 with oral. They're basically available. It's that simple. Long-acting cabotegravir ropivirin are available in high income countries and they're not available anywhere else. And the high HIV burden regions do also need long-acting prevention modalities. We haven't talked about that, but all you have to do is take that cabotagovir and ropivirin, take away the ropivirin, and cabotegravir is actually a very highly effective prevention agent if given every eight weeks. And then there's going to be a new one coming called lenacapivir, which has been in the news a lot every six months. It's not yet approved, but I think it will be by the end of this year or maybe early 2025. And it's given every six months.

Tammy Kremer:

That's prevention or treatment?

Dr. Monica Gandhi:

Lenacapivir is for prevention. And high HIV burden regions like South Africa where there's such high incidence of HIV, you really need powerful HIV prevention modalities. Not a daily pill. I mean there is daily pills, but that could be hard to take. We want this every six months prevention agent called lenacapivir for prevention to be widely available across the planet. So where are we? It's not widely available. Neither long-acting prevention or treatment is widely available. It's really only in rich countries. And that is creating a lot of very justifiable upset in the HIV community. I was at a meeting which was called the International AIDS meeting in Munich, Germany in July, and there were protests everywhere by HIV advocates. And the one thing about HIV is that we all work together, clinicians, researchers, advocates, activists, people living with HIV, non-governmental organizations. All of us work together. We protest and hold signs together.

So we have to keep on doing that because we need accessibility. We cannot be at the end of 2024 and have no accessibility of these amazing technologies that we've been talking about for the last 15 minutes and not have them available in Southern Africa or places where there's high HIV incidence and prevalence. So I hope we can talk this time next year that's going to be different, but right now, yeah, the accessibility is very disturbing.

Tammy Kremer:

Yeah, thanks for that global perspective. I know within the US, a population that we're thinking a lot about are particularly black women living in the south. Do you have a sense as to accessibility of these medications for them?

Dr. Monica Gandhi:

So that's also a great question because essentially Medicaid expansion is probably the single policy change that you can make that allows widespread accessibility of these very important HIV long-acting treatments and prevention. And there are 10 states in this country that have not yet expanded Medicaid eligibility. And those 10 states are in the south and southeast of this country. So actually black women in the south, it really depends on where you are. North Carolina is doing much better because they just expanded Medicaid but not everywhere. And if there was one thing I would urge it is ending that being a state-level decision, it would be the governors of these states deciding on Medicaid expansion. And then under Medicaid expansion, we've really been able to get these long-acting, even if you're living in the south, even if you're in a racial and ethnic minority, that can often have less access to novel technology. So I'm really hoping.

I know there's a new administration, but I also am not as gloomy as everyone else is because I think that a lot of good things have happened under Republicans for HIV. And I'm going to just hold tight to the fact that HIV is actually highest in incidence and prevalence in many Republican states in the south and southeast. And so constituents hopefully are talking to their representatives that this is not something that we can let up on, is our fight against HIV.

Tammy Kremer:

Yeah, I really appreciate that perspective. When I hear you say that, I think also about the stigma that has been attached to HIV at different times. We obviously know that it is not just a queer issue or a gay issue, but do you see that alive and well in those communities still? Or do you think that there has been some expansion?

Dr. Monica Gandhi:

Actually, the reason I got into HIV was because of the stigma. That's just a unique story about me that I grew up as an Indian American in a very white state, which was Utah, and I felt really stigmatized for the color of my skin. And so I got really curious and interested in why you'd be stigmatized for something you can't control. And it actually is what led me to go into LGBTQ health and go into HIV. But I will say that things were getting better, but now unfortunately, there has been things getting worse. And in fact, the UN AIDS report from July 2024, which kind of pointed out that we've been having setbacks in the HIV response, did point to resurgence of stigma and discrimination against different communities. For example, there's an anti-homosexuality law in Uganda that's very punitive. There's now more criminalization of sex work in places. There is a tax on gender-affirming care and transgender individuals.

So there is a lot happening that is reverse progress about what we thought we'd be in again, 2024 with stigma. And it is really hard to see those setbacks. The thing to remember about HIV is that it does tend to prey on poverty and stigma, and it is our job to reverse the conditions that can lead to the set-up of HIV infections and not doing well if you have HIV on antiretroviral therapy. That is our job.

Tammy Kremer:

An area that I'm curious about, it might be difficult to balance how technical we get on this, but I really want to understand how the different aspects of HIV treatment, what they do in the body, like what the mechanism is that actually stops the HIV virus from reproducing.

Dr. Monica Gandhi:

Well, we have to go back to that life cycle. What happens is HIV enters the human cell through two cell receptors. It's an RNA virus, so its RNA is sitting there and it needs to be made into DNA for it to go into your host cell chromosome. And so that process of RNA going into DNA is called reverse transcription. And there are two classes of drugs that work right there, and they work to stop that process of making the RNA go into DNA. Then the DNA goes and integrates itself into the host cell chromosome, and there's a class of medications that work right there, which are called integrase inhibitors. Then the virus says, "Okay, I'm going to use the machinery of the cell and make a lot more baby viruses," a big protein that has to be cut up into smaller proteins to make other viral particles.

And the final class of medications that we have are what are called protease inhibitors. They stop that cutting up of that protein so that new viral particles can't be made. So we have reverse transcriptase inhibitors, we have integrase inhibitors, we have protease inhibitors. These are all classes of medications. We have something new called a capsid inhibitor, and we have some entry inhibitors. And

having all these classes of medications available means that at least in the United States with high income settings where we can get all these medications, there really shouldn't be anyone who isn't suppressed. And it's really the social determinants of health that are translating to why people aren't suppressed. It's not the medications.

Tammy Kremer:

Thanks for that description. And then so when someone is taking PrEP, whether it's the daily pill or it's hopefully the new version that will last for six months, they're getting only some of those functions through PrEP, correct? And then someone who's actually trying to suppress the viral load is taking all of those.

Dr. Monica Gandhi:

Exactly right. So PrEP or prevention is really just taking one antiretroviral essentially, and having it be around all the time so the virus can't set up shop. Like malaria prophylaxis, when we take, if you're traveling in a malaria prone region. So PrEP is either an oral pill, which is called TDF/FTC or Truvada. It's also we have the every eight week cabotegravir, and now we're going to get the every six month injection of lenacapivir. We're going to get that soon. And PrEP and treatment together is how we're going to end the HIV epidemic.

Tammy Kremer:

I'm curious to ask you a bonus question about Covid, if you're up for it.

Dr. Monica Gandhi:

Yes.

Tammy Kremer:

Something that I've been curious about is seeing a lot of activism happening about long Covid in particular. And I know you've been deeply involved in Covid work from the very beginning, and you just wrote this book Endemic, and you could put it in your own words, but looks at what we can learn from the HIV epidemic for future epidemics.

Dr. Monica Gandhi:

Exactly. It was really saying that if you are a long-term HIV person, we didn't do this exactly right with Covid because we should have learned a lot more lessons about harm reduction, about education, about less coercive responses, about celebrating biomedical breakthroughs. And then it ends with kind of a pandemic preparedness plan for the future. And it's by Mayo Clinic Press, and only my mother's read it. So if anyone else wants to read it, that'd be great.

Tammy Kremer:

What are some of the top lessons you would bring forward from that book?

Dr. Monica Gandhi:

One thing is around the concept of harm reduction. Early in the HIV movement, what happened is that Reagan, who was the president when HIV was first described, there was kind of a just say no, abstinence only approach. And then because public health officials and ID doctors tend to be left, they really

rebelled against that. And they said, "Well, no, actually we have human needs. People want to be sexually active with each other. They express their human needs, and we're going to tell you how to stay safer and not get HIV." Use of condoms, eventually treatment, eventually PrEP. And that was called a harm reduction strategy, not abstinence only, not abstinence based, but just taking human needs into account. And what we did in Covid was less harm reduction. It was like, shut down all of society, shut down the schools. Don't take people's loneliness into account, their human needs to be around each other. And when the vaccine came out, I don't think that we celebrated it enough that this was the key to unlock society like Europe.

We said, "Yeah, there is, great, it's a vaccine, but still wear masks, still don't be around each other." And it didn't seem like that messaging was consistent with a harm reduction principle, which is celebrate biomedical advances. So it was really just pointing out all the things we did in HIV and saying, "I wish we would've done a lot more of that in Covid." And in the future, we need a pandemic playbook that takes people's needs into account that are not just related to the virus, that celebrates vaccines and treatments, and that does understand that people really want to be back to normal. People like being around each other, it's actually really important. And I hope that it will maybe get rid of some of this distrust because I will say that the way we managed Covid led to a decrease in trust in public health, and that's not where we want to be if, God forbid, there's another pandemic.

Tammy Kremer:

Yeah. I appreciate the way you also talk about the political spectrum in terms of how we navigate that strategically and finding the ways that we can maintain this sense of what is common across different political perspectives.

Dr. Monica Gandhi:

Right. I think there are some hard truths in science, and then there are places where politics makes decision. And we were wildly different in our responses by state according to politics. And that's not how it should be. It should be that we put best principles together, have a multidisciplinary team, have child development experts and the decision makers along with infectious disease experts, put it all together and come up with a comprehensive, holistic approach.

Tammy Kremer:

So we're coming towards the end here. I like to ask all of our guests, what's one thing you hope we can create by coming together for sexual health?

Dr. Monica Gandhi:

One thing that we can all say is that sexual needs are important and people have sex. That's why we need to test everyone at least once in this country for HIV, it happens. And it's good that it happens. It's a human need. But we can stay safe within what we strive for in human connection, which is being around each other. And those ways to stay safer from sexually transmitted infections are really powerful modalities now for HIV prevention, choose your shot or pill here in the United States at least. We also have something called Doxy PEP, which is taking after sex a pill that would prevent other sexually transmitted infections, specifically syphilis and chlamydia. And that's very exciting. And I do think Doxy PEP, which is now endorsed by the CDC, has been responsible for some of our decreasing syphilis rates around the country. And just remember that no one else's sex life is any of your business and let people do whatever they want. Just give people tools to stay safe from infections. Because the entire point is that anything that's lovely and pleasurable in life should not come with an infection.

Tammy Kremer:

Yes. And where can our listeners find you?

Dr. Monica Gandhi:

I do have an X account still. I also am on LinkedIn and I am at UCSF. And if you look under just my name and UCSF, you'll see my profile is there. And it really just is a pleasure to work in HIV. I always think of it this way, but it's really not an infection, it's a movement. It's a political movement. We're all together on this, and I would be happy to talk to anyone anytime. I get a lot of emails about Long Acting. If you're a provider out there and want to use Long Acting, we have a protocol for you. We'd love to talk to you about it. We can walk you through the whole thing. So yeah, just please email me anytime. I'm really easy to find.

Tammy Kremer:

Wonderful. Well, thank you so much, Monica. I really appreciate all the work that you do and getting to hear a little bit from you directly today is just really a privilege.

Dr. Monica Gandhi:

Thank you so much for having me.

Tammy Kremer:

Thanks for listening. And please follow and rate us wherever you get your podcasts to help more people find us. And hey, how about sharing this with a friend or a colleague you'd like to talk with about sexual health? Check out the show notes for the resources mentioned this episode and the transcript of the show. Connect with us on Instagram @ComingTogetherPod, on X @CaliforniaPTC, and at ComingTogetherPod.com. This podcast is produced by me, Tammy Kremer, with our co-producer and editor, Isaiah Ashburn, brought to you by the California Prevention Training Center. We're based at the University of California, San Francisco and would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.