POSITIVELY AWARE
NOV+DEC 2024

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A DAY WITH HIV

EVERYDAY MOMENTS IN EXTRAORDINARY LIVES

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—**KATIE WILLINGHAM**

ONE OF FOUR
SPECIAL EDITION
FOLDOUT COVERS

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DETROIT, MICHIGAN**
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—KRISHEN SAMUEL

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—**GABRIELLA'S MOM**

POSITIVELY AWARE
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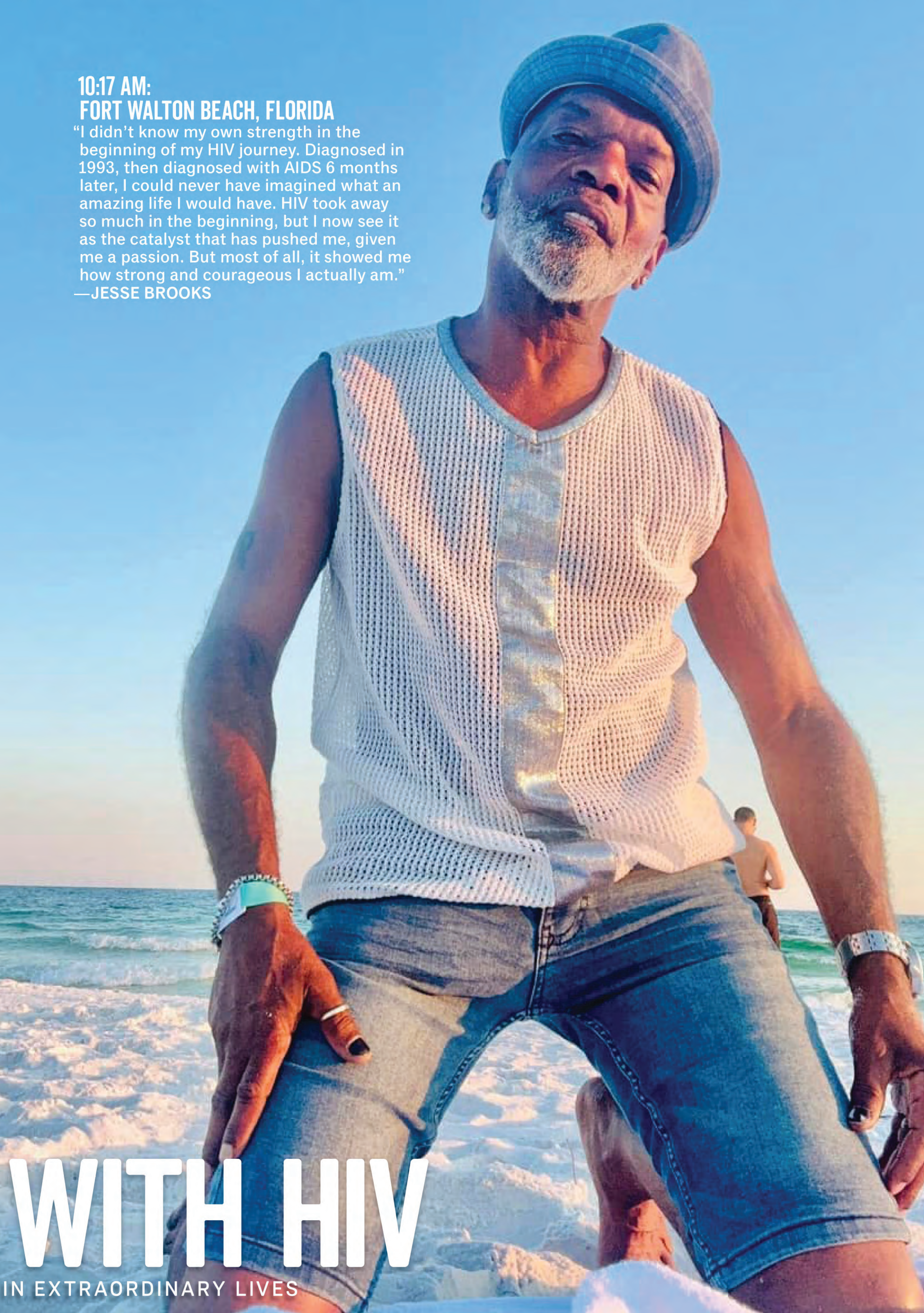
CONEY ISLAND, NEW YORK
“I’m balancing the Wonder Wheel, just as I balance my healthcare; living with HIV 32 years.”
—**LILLIBETH GONZALEZ**

A DAY

EVERYDAY MOMENTS



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—**JESSE BROOKS**

WITH HIV

IN EXTRAORDINARY LIVES

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TPAN was founded in 1987 in Chicago as Test Positive Aware Network, when 17 individuals living with HIV gathered in a living room to share information and support in response to the HIV/AIDS epidemic. POSITIVELY AWARE is the expression of TPAN's mission to share accurate, reliable, and timely treatment information with anyone affected by HIV.

ONE ISSUE, FOUR FOLDOUT COVERS. This issue features four versions of the foldout cover, each with photos from **A Day with HIV**, POSITIVELY AWARE's annual anti-stigma campaign. A Day with HIV portrays 24 hours in the lives of people affected by HIV. On September 22, people around the world photographed a moment of their day, posted the picture to their social media and shared their story using the hashtag #adaywithhiv. An online gallery is on view at adaywithhiv.com.

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EDITOR'S NOTE

Rick Guasco
@rickguasco

A life made better

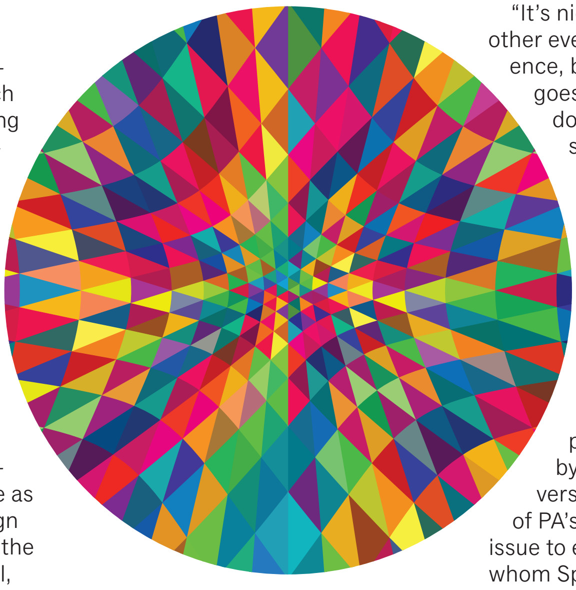
Through shared experience, I find community. If it weren't for HIV, there are so many interesting people I never would've met. They've added to my life and have made me a better person. My life has been made richer, fuller—and bigger—because of this damned virus. That's been my life's lesson.

HIV forced me to go outside of my comfort zone. Having developed Kaposi sarcoma, an AIDS-defining form of skin cancer, I couldn't hide the lesions on my face and body. If I didn't have a choice, then I might as well face the stigma head on. It was a practical decision; if I wasn't going to become another "victim" of AIDS, I was not going to let myself fall victim to stigma.

Taking that step forward opened up my world and introduced me to new people, which gave me hope. I started learning about the science of HIV treatment and how HIV works. I also discovered that I was interested in other people who were also living with, or affected by, HIV. If you care about your own survival, if you want to end HIV, I realized that you have to *care* about people with HIV.

Looking through the pictures in this issue from A Day with HIV, our annual anti-stigma campaign, I hope you'll be as inspired as I am. The campaign displays pictures all taken on the same day—the first day of fall, September 22—by people living with and affected by HIV. In this collection of images, see a broad tapestry with HIV as the common thread until you realize that this isn't about a virus. A Day with HIV is about individuals, all of us, and how we are linked by our common humanity, regardless of HIV status. The special section of pictures begins with an introductory story on page 36.

Elsewhere in this issue, Justin Terry-Smith talks candidly with Mark S. King about his harrowing experience in how he acquired HIV and his journey of recovery and self-acceptance in "The echoes of sexual assault" (page 32). A personal note of deep appreciation to Justin for choosing to share his story in the hopes that it will reach readers who've lived through similar experiences.



Scott Schoettes, who writes PA's occasional Poz Advocate legal column, is one of the lead attorneys in a major court case to force the U.S. Department of Defense to stop discriminating against people living with HIV enlisting and serving in the military. He shares his experience and insight in the continuing battle, which as we go to press, could see a new development in the case.

There were a number of findings and developments announced at October's IDWeek 2024 infectious disease medical conference in Los Angeles. Contributing writer Larry Buhl attended the conference and provides an overview (page 18). He also takes a closer look at an IDWeek session about how care providers can offer better health outcomes for patients who use methamphetamine (page 20) and outlines vaccine guidelines for people living with HIV (page 22).

Our report on the closing plenary session of last September's U.S. Conference on HIV/AIDS (known as USCHA), which focused on HIV efforts in Latinx communities, highlights the need for a renewed commitment.

My life has been made richer, fuller—and bigger—because of this damned virus. That's been my life's lesson.

"It's nice that we see each other every year at this conference, but when each one of us goes back to our towns, we don't hear [from anyone]," says Areley Westley, an immigrant and longtime LGBTQ+ advocate originally from Honduras. "We need to stay connected and to actually be in solidarity with each other in order to build power. We can build power together."

The report starts on page 23 and is followed by a Spanish-language version on page 26 as part of PA's continuing effort each issue to engage readers for whom Spanish may be their primary language.

I always say that POSITIVELY AWARE sells a product—hope, in the form of news, information and the sharing of people's stories with HIV. It's my hope that that's what you find in this issue.

You are not alone.

Rick

GUASCO: JOHN GRESS · ISTOCK

Briefly

ENID VÁZQUEZ @enidvazpa

Medicare coverage now includes PrEP

Medicare now covers the expense of medication used to prevent HIV—PrEP (pre-exposure prophylaxis). The announcement came from the Centers for Medicare & Medicaid Services (CMS).

"**Effective immediately, PrEP will be available at no cost to older adults and individuals with disabilities on Medicare—no cost-sharing, co-pays or deductibles**," reported Terri L. Wilder, MSW, HIV/Aging policy advocate for SAGE, the national advocacy organization for LGBTQ+ elders, on September 30. GO TO sageusa.org.

According to CMS, "Specifically, CMS has determined that PrEP using antiretroviral drugs to prevent HIV is reasonable and necessary for the prevention of an illness or disability; is recommended with a grade of A by the United States Preventive Services Task Force (USPSTF); and is appropriate for individuals entitled to Medicare benefits under Part A or enrolled under Part B."

Medicare coverage includes up to eight individual counseling visits every 12 months, up to eight HIV screening tests every 12 months and a single screening for hepatitis B virus (HBV).

The CMS announcement included PrEP on-demand scheduling (around the time of sex) and PrEP used to prevent HIV during injection drug use. The three PrEP medications currently on the market are the oral medications Descovy and Truvada and the long-acting injectable Apretude, taken as one injection every two months.

The document also acknowledges potential problems with accessing PrEP from both people seeking to take it as well as healthcare providers. These challenges include a lack of knowledge of its availability (especially among primary care providers), misperceptions around the potential for HIV acquisition, distrust of providers and stigma.

GO TO cms.gov/medicare-coverage-database/view/ncacal-decision-memo aspx?proposed=N&ncaid=310.

Updated U.S. statistics on HIV testing, prevention and treatment in MSM

The 2023 update on HIV testing, treatment and prevention with PrEP in men who have sex with men (MSM) was released in September by the U.S. Centers for Disease Control and Prevention (CDC). The update came from the CDC's National HIV Behavioral Surveillance (NHBS) research.

Between 2017 and 2023:

- HIV testing within 12 months of the survey went up 1%
- Awareness of PrEP increased by 8%
- PrEP use expanded 20%
- HIV treatment went up 4%

All in all, 78% of all the gay and bisexual men surveyed reported being tested for HIV within 12 months of the survey. The surveillance report called testing "the first step toward engaging in HIV prevention or treatment services."

A greater percentage of the men, 93%, were aware of pre-exposure prophylaxis (PrEP) for the prevention of HIV, with 45% of the men saying they had used it. But, the CDC reported, racial and ethnic disparities continued to exist in PrEP awareness and use.

"**Understanding and addressing barriers to PrEP use among Black and Hispanic/Latino gay and bisexual men are needed**," the report stated.

As for HIV treatment, nearly all of the men who reported a positive status said they are currently taking antiviral medication (96%).

VÁZQUEZ: JOHN GRESS · BUILDING BLOCKS: ISTOCK

TOP OF THE NEWS

➤ Medicare coverage now includes PrEP ➤ New HIV cases drop in San Francisco ➤ Latino HIV summit hosted by ONAP director Francisco Ruiz at the White House ➤ Zimbabwean journalist joins AVAC's advocacy ➤ Proposal to expand HIV-positive transplants outside of research ➤ Una cumbre sobre la respuesta al VIH en las comunidades Latinas de La Casa Blanca ➤ Wellness Chronicles: short videos focus on health for Black women and girls

To read *HIV Infection Risk, Prevention and Testing Behaviors Among Men Who Have Sex with Men, National HIV Behavioral Surveillance 19 U.S. Cities, 2023*, **GO TO** cdc.gov/hiv-data/nhbs/index.html. Other surveillance reports conducted by NHBS include people who are "heterosexually active."


ANNA MITI

Zimbabwean journalist joins AVAC's advocacy

Health journalist and gender rights advocate Anna Miti has joined AVAC's The Choice Agenda (TCA) as its new co-moderator.

"Based in Harare, Zimbabwe, Anna is a seasoned journalist, advocate for gender equality, an AVAC Cure Fellow, former AVAC Advocacy Fellow and co-convener of the Zimbabwe Media Science Cafe, who brings her passion for amplifying community voices to this role," AVAC announced in September.

The U.S.-based HIV prevention advocacy group started TCA in 2022 as "a global forum for advocacy on the latest in HIV prevention. With monthly webinars hosting informed discussions and a moderated listserv of nearly 3,000 subscribers from 40+ countries, TCA offers the HIV prevention community a platform to come together, learn from one another and chart the way forward."

"As a long-time member of the TCA, I have valued it as a place for robust discussions and a vital platform to access new, timely and relevant information," Miti said. "I am excited to now contribute to this platform as co-moderator. Together with other advocates, **I aim to strengthen the TCA's impact and contribute even more to HIV and science advocacy**."

She joins co-moderator Jim Pickett, of the U.S., who like her is a journalist. Pickett is a longtime advocate for HIV microbicides.

GO TO avac.org/project/choice-agenda.

Proposal to expand HIV-positive transplants outside of research

A proposed rule change would affect the transplantation of kidneys and livers from donors living with HIV to recipients who are also living with HIV. The U.S. Department of Health and Human Services is proposing to **lift the requirement that such transplants only be done in a clinical research environment and under an institutional review board**. Instead, transplantation of a kidney or liver from an HIV-positive donor would be allowed for people living with HIV who are not involved in research. The proposed change to the HOPE Act (HIV Organ Policy Equity Act), issued September 12 in the Federal Register, was based on a favorable review of transplants involving HIV that was conducted by the Organ Procurement and Transplantation Network (OPTN).

Wellness Chronicles: short videos focus on health for Black women and girls

You can gain a world of wisdom in less than five minutes from a new short video series, the Wellness Chronicles. **Community-based experts discuss the needs of Black women and specific girls in matters related to sexual health, STIs and HIV**.

In the first video, dropped November 1, Robbin Alexander of Sinai Hospital of Baltimore offers the insight she's gained and the knowledge she's learned from three decades of work as a case manager and community health worker. Alexander calls the increasing numbers of HIV cases in Black women "a crisis fueled by a lack of education, fear, judgment and stigma."

"This causes many women to hesitate in getting tested, returning for their results, or disclosing their status," she explains. "Misconceptions and stereotypes about HIV continue to persist… And there are many misconceptions.

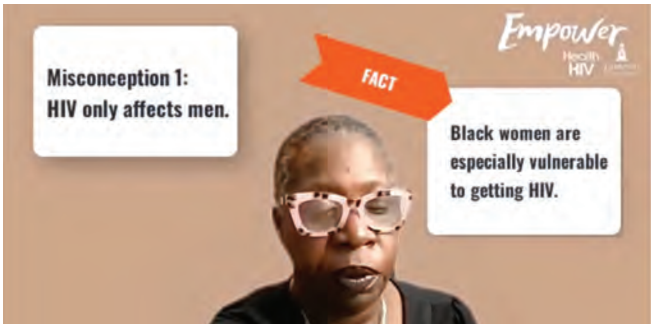
"Misconception number one is that HIV only affects men. HIV can affect anyone and everyone.

"Misconception two: only people who use drugs get HIV. HIV can spread through many ways…

"Misconception three, that HIV is a death sentence. With the right treatment, people living with HIV can live long and healthy."

Alexander lists several steps that can be taken to help women, calling them "strategies we can use to reduce the stigma and empower Black women."

"Educate and advocate," she says. "We must educate ourselves and our communities about HIV by participating in training programs, keeping up with the latest prevention and treatment and sharing what we learn with others. Also, provide support. Create spaces for women to share their experiences without judgment, to foster genuine connection and healing. It's very important. We must do something like formalize support groups and something more casual than just organized by friends and colleagues, being able to support and talk to each other.



ROBBIN ALEXANDER

Also, promote an open dialog. Invite women with lived experiences to share with other women in their communities. Share their insights and their experiences. That will inspire action and engage with the community. Influences—involve trustworthy health organizations, faith leaders and advocates to speak openly about HIV and help normalize the conversation, to reduce stigma.

"Together, we can change the narrative," Alexander said in her conclusion. "Let's commit to breaking the silence and building supportive environments for all women."

The Wellness Chronicles was created through the Empower program of the non-profit organization HealthHIV in collaboration with Howard University, an HBCU (historically Black college and university).

"Racism, poverty and lack of access to quality care significantly impact Black women's health," HealthHIV writes about the Empower project. "Higher rates of sexually transmitted infections (STIs), lower rates of testing and higher rates of stigma continue to make Black women vulnerable to poorer health outcomes, including acquisition of HIV or STIs. As a traditionally marginalized group, and for many multi-layered reasons, educational and engagement opportunities and health data for and by Black women is limited."

Calling Howard University "a champion of Black women," HealthHIV said the collaboration will "conduct research, provide education, spark community engagement and embrace the arts to create a path to empowerment for Black women."

GO TO healthhiv.org.

To view the first video, **GO TO** bit.ly/4fTOvEJ. Episode 2 discusses STI awareness. Episode 3 reviews prenatal strategies to prevent HIV and syphilis.

New HIV cases drop in San Francisco

There's good news from San Francisco: new cases of **HIV in the city dropped by 20% from 2022 to 2023**. That was a decrease from 167 new cases last year to 133 this year.

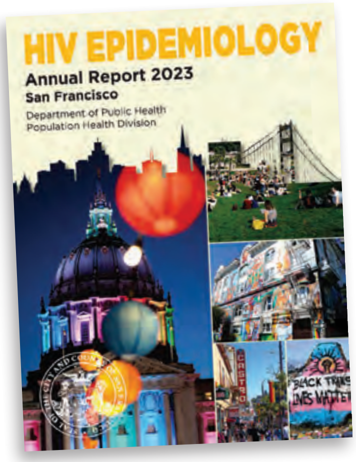
For Latine individuals the decrease was even greater, 46% (from 74 new cases in 2022 to 40 in 2023).

The San Francisco Department of Public Health (SFDPH) released its 2023 HIV Epidemiology Annual Report in September. SFDPH reported that the city has experienced a 59% decrease in new HIV cases since 2014, compared to a 3% decrease nationally.

Moreover, 95% of people diagnosed in 2023 were linked to care within a month. Of the people diagnosed in the first nine months of 2024, 80% reached undetectable viral load within six months.

The news for individuals without stable housing was not as good, however. SFDPH reported that these individuals "comprise an elevated proportion of new diagnoses each year, accounting for 23% of 2023 diagnoses" and "only two-thirds [66%] were virally suppressed in 2023."

Additionally, SFDPH said that while people living with HIV continue to live longer, drug overdoses accounted for 19% of their deaths between 2019 and 2022.



HIV EPIDEMIOLOGY
Annual Report 2023
San Francisco
Department of Public Health
Population Health Division

Overall, San Francisco had 15,543 individuals living with HIV last year.

The department has opened what it calls *Health Access Points* (HAPs) in collaboration with community partners to provide easier access to prevention, care and treatment. The newest HAP, The Lobby, prioritizes people who are unstably housed or who use recreational drugs. It is located on the first floor of building 80 (UCSF's Ward 86 clinic).

Other HAP locations include the Latino Wellness Center, Trans Thrive, LYRIC drop-in center, 1930 Market Street and 470 Castro Street. **GO TO** sf.gov.

SFDPH also noted that the "renowned San Francisco City Clinic provides comprehensive prevention and care HIV services with bilingual staff."

According to the annual report, the use of HIV prevention medication (PrEP, pre-exposure prophylaxis) increased for all ethnic and racial groups of men who have sex with men (MSM), from 22–27% in 2015 to 71–78% by 2023.

"To ultimately succeed in our fight against HIV, it is critical for people to know and understand the many services that are available to them, and that services continue to evolve and improve, which cannot be done without continued planning and coordination with community, academic and health system partners," said Susan Philip, MD, MPH, health officer for the City and County of San Francisco and director of the Population Health Division for SFDPH, in a press release.

"This report gives us many reasons to be encouraged and shows that our efforts are making a difference," said SFDPH director of health Grant Colfax, MD. "Incredible advancements have been made in HIV prevention and care, and we must continue to make sure that communities across San Francisco have access to high-quality, culturally competent services so that this report is part of a sustained trend that marches us towards a day when there will be no new HIV infections."

According to the report 11% of the people living with HIV in California live in San Francisco.

READ the report: sf.gov/resource/2024/hiv-epidemiology-unit-reports.

Latino HIV summit hosted by ONAP director Francisco Ruiz at the White House

Appointed in May by President Joseph Biden as director of the White House Office of National AIDS Policy (ONAP), longtime HIV advocate Francisco Ruiz came with a background in national outreach work, which Ruiz used to quickly mobilize a community summit that took place in September.

Writing for HIV.gov, Ruiz said, “The ¡Adelante! Summit seeks to unite leaders from across the federal government, civic and social organizations, the private sector, the arts and entertainment industries, healthcare professionals and communities throughout the nation. The intention of the convening is to raise greater awareness of HIV among Latinos and foster multidisciplinary collaboration, coordination and commitment to strengthen efforts addressing the HIV epidemic in Latino communities through a comprehensive and holistic approach.

“The health inequities within Latino communities remind us of the urgent work that still lies ahead, particularly in our efforts to address HIV in this country,” Ruiz continued. “This Summit is intended to galvanize new and existing partners in this vital work, engaging everyone to do their part to drive progress forward.”

Ruiz noted that as a group, **Latino gay men represent the highest number of new HIV cases in the country**, according to the most recent surveillance reports from the Centers for Disease Control and Prevention (CDC). “Other data indicate suboptimal rates of knowledge of HIV status, linkage to HIV care and viral suppression, as well as high rates of HIV stigma among Latinos,” he added.

GO TO hiv.gov/blog/white-house-to-convene-summit-on-response-to-hiv-in-latino-communities.

TO VIEW a brief interview with Ruiz about the summit, with Miguel Gomez of HIV.gov’s YouTube channel, **GO TO** youtube.com/watch?v=pR1HMJVDmUg. (In the video, Ruiz rocks a great mariachi look.)

Before heading up ONAP, Ruiz spent a decade at the CDC as the senior advisor for Program Innovation and Coordination within the Division of HIV Prevention. Previously, he worked at NASTAD (National Alliance of State and Territorial AIDS Directors), coordinating with public health departments to address HIV among groups most affected, specifically Black, Latine and LGBTQ+ communities.

ONAP was first established in 1994 by President Bill Clinton. The office was shuttered in 2021 during the Trump administration. Ruiz succeeds Harold J. Phillips, who was appointed director when President Biden reopened ONAP.

A profile of Ruiz by Mathew Rodriguez was published September in *POZ* magazine, **AVAILABLE IN** English (poz.com/article/power-story-told and Spanish (poz.com/article/el-poder-de-una-historia-bien-contada-francisco-ruiz).

FRANCISCO RUIZ AT USCHA 2024 IN SEPTEMBER.

RUIZ: SEAN BLACK

Una cumbre sobre la respuesta al VIH en las comunidades Latinas de La Casa Blanca

En respuesta a los datos preocupantes sobre los diagnósticos de VIH entre las comunidades latinas en los Estados Unidos, la Oficina de Política Nacional sobre el SIDA (ONAP, por sus siglas en inglés) de la Casa Blanca [hizo] un llamado a participar en la Cumbre ¡Adelante!: una convocatoria de la Casa Blanca para acelerar la respuesta nacional al VIH en las comunidades latinas. Para garantizar una amplia participación, la ONAP ofrece una opcion virtual para las partes clave de la cumbre el 23 de septiembre de 2024.

Esta reunión llega en un momento crucial. Si bien los latinos representan aproximadamente el 19% de la población de EE. UU., representaron casi un tercio de todos los nuevos diagnósticos de VIH en 2022. En particular, **los hombres homosexuales latinos ahora representan el número más alto de nuevos casos de VIH en el país**, según los informes de vigilancia más recientes de los Centros para el Control y la Prevención de Enfermedades (CDC, por su sigla en inglés) de EE. UU. Otros datos indican tasas subóptimas de conocimiento sobre el estado del VIH, la vinculación con la atención del VIH y la supresión viral, así como tasas elevadas con respecto al estigma del VIH entre los latinos.

La Cumbre ¡Adelante! busca unir a líderes de todo el gobierno federal, organizaciones cívicas y sociales, el sector privado, las industrias de las artes y el entretenimiento, profesionales de la salud y comunidades de todo el país. La intención de la convocatoria es crear una mayor conciencia sobre el VIH entre la población latina y fomentar la colaboración, la coordinación y el compromiso multidisciplinario para fortalecer los esfuerzos para abordar la epidemia del VIH en las comunidades latinas a través de un enfoque integral y holístico.

Las inequidades en salud dentro de las comunidades latinas nos recuerdan el trabajo urgente que aún queda por hacer, particularmente en nuestros esfuerzos para abordar el VIH en este país. El objetivo de esta cumbre es movilizar a los socios nuevos y a los ya existentes en esta labor vital, comprometiendo a todos a poner de su parte para impulsar el progreso.

AGRADECIMIENTO ESPECIAL al fuente de contenido: Francisco Ruiz, MS, director de la Oficina de Política Nacional sobre el SIDA de la Casa Blanca. Un perfil de Ruiz por Mathew Rodríguez fue publicado en septiembre en la revista *POZ*, disponible en español (poz.com/article/el-poder-de-una-historia-bien-contada-francisco-ruiz) y inglés (poz.com/article/power-story-told).

Briefly

NATIONAL LATINX AIDS AWARENESS DAY 2024

Start Treatment. Stick to It. Get Better.

This year's National Latinx AIDS Awareness Day (NLAAD), October 15, focused on health care for living with HIV. This includes dealing with challenges to good health, such as stigma. This year's theme was *Start Treatment. Stick to It. Get Better.*

"NLAAD is an opportunity to help address the disproportionate impact of HIV in Hispanic/Latinx communities, promote HIV testing and stop HIV stigma," noted HIV.gov. **GO TO** hiv.gov/events/awareness-days/latino.

This year is the 21st anniversary of NLAAD, which was first launched in 2003 by the Hispanic Federation and the Latino Commission on AIDS (LCOA). Today, LCOA continues to coordinate NLAAD efforts and events across the country.

"In 2024, **NLAAD wants to focus on HIV treatment and address HIV stigma**," said LCOA in a press statement. "Not only do we want the community to have a better knowledge of the options available to treat HIV and to have a healthy life, reaching undetectable levels of viral load, but also bring attention to the obstacles that the Latinx community must confront to access treatment, which includes among several factors HIV stigma. This year's campaign is directed at the entire community but focused on people who live with HIV. The campaign urges them to choose one of the many treatment options to maintain their health, reach undetectable viral load and not pass the virus to others (*treatment as prevention*)."

LCOA reported statistics from the Centers for Disease Control and Prevention (CDC) showing that in 2022, Hispanic/Latinx people made up 32% of the 37,891 new HIV diagnoses in the country and dependent areas, though they represent only 19% of the U.S. population. The agency highlighted the need to focus particularly on young gay men and individuals living in the South, who made up more than half of the new HIV diagnoses that year.

"Southern states continue to confront rising HIV diagnoses and alarming social stigma, and discrimination faced by our most vulnerable communities," said Judith Montenegro, director of LCOA's Latinos in the South initiative. "NLAAD is an opportunity for all of us to bring visibility to the resources available in our communities for testing, prevention and care."

GO TO nlaad.org and latinoaids.org.

HIV TESTING IS QUICK AND EASY, HIGHLY CONFIDENTIAL, PAINLESS, WIDELY ACCESSIBLE AND GENERALLY FREE. GET THAT TEST DONE.

EL DÍA NACIONAL LATINO DE CONCIENTIZACIÓN SOBRE EL SIDA 2024

Empieza tu Tratamiento. Mantenlo. Vive Mejor.

El 15 de octubre es el Día Nacional Latino de Concientización sobre el SIDA (NLAAD por sus siglas en inglés). NLAAD promueve las pruebas diagnósticas, la prevención y el tratamiento del VIH dentro de diversas comunidades para abordar los desafíos de salud que enfrenta la comunidad hispana/latina. La campaña de NLAAD 2024 reúne a comunidades, proveedores de servicios y organizaciones que brindan servicios a hispanos/latinos en todo Estados Unidos y territorios bajo un lema: "Empieza tu Tratamiento. Mantenlo. Vive Mejor".

NLAAD fue observado por primera vez en 2003 por la Comisión Latina sobre el SIDA y la Federación Hispana. El año pasado, en 2023, NLAAD cumplió 20 años y se centró en las diferentes medidas para prevenir el VIH haciendo posible que la población viva y disfrute de la vida con menos preocupaciones.

En 2024, **NLAAD quiere centrarse en el tratamiento del VIH**. No solo queremos que la comunidad tenga un mejor conocimiento de las opciones disponibles para tratar el VIH y tener una vida saludable, alcanzando niveles indetectables de carga viral, sino también llamar la atención sobre los obstáculos que debe enfrentar la comunidad latina para acceder al tratamiento, lo que incluye entre varios factores, el estigma del VIH. La campaña de este año está dirigida a toda la comunidad, pero se centra en las personas que viven con el VIH. La campaña les insta a elegir una de las muchas opciones de tratamiento para mantener su salud, alcanzar una carga viral indetectable y no transmitir el virus a otras personas (Tratamiento como Prevención).

Según los Centros para el Control y la Prevención de Enfermedades (CDC), las personas hispanas/latinas representaron el 32% de los 37,891 nuevos diagnósticos de VIH en los Estados Unidos y áreas dependientes en 2022, a pesar de representar solo el 19% de la población estadounidense. Este porcentaje aumenta continuamente año tras año. Es necesario abordar el estigma, las barreras lingüísticas y las barreras a la atención médica que contribuyen a la epidemia del VIH entre las personas hispanas/latinas, particularmente entre los jóvenes homosexuales y la región sur de nuestro país, que representó más del 50% de los nuevos casos.

"Los estados del sur continúan enfrentando un aumento en los diagnósticos de VIH y un alarmante estigma social y discriminación que enfrentan nuestras comunidades más vulnerables. NLAAD es una oportunidad para que todos nosotros demos visibilidad a los recursos disponibles en nuestras comunidades para la realización de pruebas, la prevención y la atención clínica", declaró Judith Montenegro, directora de Latinos en el Sur, un projecto de la Comisión.

"Para nuestra 22ª campaña NLAAD, notamos que existe aún una gran necesidad de continuar promoviendo las pruebas de diagnóstico, la prevención y el tratamiento del VIH entre nuestra comunidad, y una mayor necesidad de educar a la población sobre los recursos con los que contamos en estos días para prevenir y tratar el VIH, junto con educar a nuestros funcionarios electos sobre las disparidades que enfrenta nuestra comunidad latina para acceder a las pruebas, prevención y tratamiento del VIH", dijo Luis Mares, director de Movilización Comunitaria de la Comisión. "Hay un largo camino por recorrer hasta llegar al final de esta epidemia".

VISITE A nlaad.org/es y latinoaids.org.

AGRADECIMIENTO ESPECIAL
al la Comisión Latina sobre el SIDA
por este artículo.

ISTOCK

A once-weekly HIV treatment pill looks promising

A first-ever weekly oral drug combo looks to be as effective as daily medication

BY **RICK GUASCO**

Newly announced results from a phase 2 clinical trial show that a drug combination—islatravir and lenacapavir—holds promise as the first-ever weekly oral pill for HIV treatment, comparable to a single-tablet regimen taken every day.

At 48 weeks, the drug combo had a 94.2% success rate in keeping adult participants undetectable, with an HIV viral load less than 50 copies/mL of blood. This compared to 92.3% for the group that remained on Biktarvy. No one from either group had a viral load of 50 or greater at the start of the trial.

The combo is a collaboration between Merck, manufacturer of islatravir (ISL), and Gilead Sciences, maker of lenacapavir (LEN).

The open-label study involved 104 virologically suppressed adults who were taking the brand name daily oral HIV medication Biktarvy (bictegravir, emtricitabine and tenofovir alafenamide); half of the adults were switched to a once-weekly ISL+LEN combination of islatravir 2 mg and lenacapavir 300 mg, while the other half remained on Biktarvy. Median age of the participants was 40, ranging from 20–76 years of age. Of the participants, 18% were cis women, 50% were "non-white" (according to a press release) and 29% were Latine.

Data from the study (known as NCT05052996) were presented on the last day of IDWeek 2024, the infectious disease medical conference that concluded October 19 in Los Angeles. Earlier this year, 24-week data had been presented at the 31st Conference on Retroviruses and Opportunistic Infections (known as CROI).

Both drugs are being tested individually and in combination with other HIV medications. Also known as MK-859, islatravir is a nucleoside reverse transcriptase translocation inhibitor (NRTTI). In studies, islatravir is being paired up with other antiretrovirals to determine dosing options for potential daily and once-weekly HIV treatments.

'The future of HIV treatment is person-centered, with long-acting options tailored to help meet the needs and preferences of people affected by HIV'

Lenacapvir is already approved as a six-month shot—but only as part of a treatment regimen that includes oral medications, and only for people living with HIV who are heavily treatment-experienced with few other treatment options left. While most HIV medications target a single step of HIV's replication process, lenacapavir, the first-in-class HIV capsid inhibitor, aims at different stages of the virus' lifecycle. Lenacapavir made news recently with results from two PURPOSE clinical trials showing the drug to be highly effective in preventing HIV among cisgender women and in men and trans men who have sex with men.

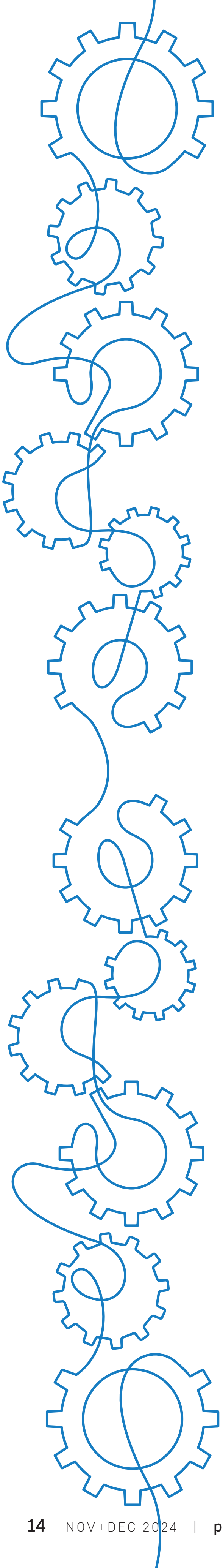
"The future of HIV treatment is person-centered, with long-acting options tailored to help meet the needs and preferences of people affected by HIV," said Jared Baeten, MD, PhD, Gilead's senior vice president and head of the virology therapeutic area. "There is no 'one size fits all' approach."

The most common side effects experienced by the ISL+LEN group were dry mouth (19%, or 10 out of 52) and nausea (3.8%, or 2 out of 52). In the Biktarvy group, 5.8% (3 out of 52) reported side effects, none were serious. Two participants stopped taking ISL+LEN, experiencing adverse events unrelated to the medication.

There was no significant difference seen from baseline in CD4+ T cell counts or absolute lymphocyte counts in either group.

"We are pleased to see these encouraging 48-week data for this once-weekly oral combination regimen and advance to phase 3 clinical trials in collaboration with Gilead," said Dr. Elizabeth Rhee, vice president of Merck's Global Clinical Development.

This is still early days; more testing is needed before a weekly HIV medication becomes available. Weekly oral ISL 2 mg + LEN 300 mg is being further evaluated as a fixed-dose regimen in two phase 3 studies, NCT06630286 and NCT06630299.



Prostate cancer study

BY **LARRY BUHL**

Johnson & Johnson Innovative Medicine is recruiting a Phase 3 clinical study, called LIBERTAS, to explore several questions about metastatic prostate cancer. The twist is that the company is actively looking for transgender volunteers to evaluate, making it the largest, and one of the only, oncology studies of its kind.

LIBERTAS researchers will evaluate the clinical risk factors and underlying biology of prostate cancer, specifically to determine whether patients who reach an undetectable level of chemical biomarkers for prostate cancer—prostate specific antigens or PSAs—could have their cancer therapy cut back without risking escalation of the cancer.

Prostate cancer is diagnosed in nearly 300,000 people in the U.S. every year, according to the National Cancer Institute, and claims nearly 35,000 lives annually. What's known about prostate cancer is based on cisgender men, however. The LIBERTAS study, developed in partnership with LGBTQ+ groups at Johnson & Johnson and external patient advocate groups including Fenway Health, is attempting to broaden the understanding of prostate cancer to include all people with prostates, which includes transgender women.

Regarding trans women in the study, LIBERTAS researchers want to know whether patients with newly diagnosed metastatic prostate cancer can safely stop taking androgen deprivation therapy (ADT), a treatment for prostate cancer that stops the growth of cancer cells by lowering the amount of androgens (male sex hormones). ADT is a common part of gender-affirming hormone therapy for suppressing masculine secondary sex characteristics like facial hair, and it complicates the prostate cancer risk assessment for trans women.

Not much is known about the risk of prostate cancer for trans women. A 2023 study indicated that the chances of prostate cancer in trans women may be higher than previously thought, and that patients on gender-affirming hormone therapy (GAHT) had the most aggressive cancer, possibly due to delayed diagnoses. Because testosterone is fuel for prostate cancer it would make sense that GAHT would lower the risk of cancer, but researchers determined that the relationship between female hormones and prostate cancer is more complicated, and may lead doctors to misinterpret "normal" PSA levels in people on gender-affirming hormones—levels that have been based on data from cisgender men. Right now, there are no PSA ranges for trans women. A working theory is that current prostate cancer testing may give trans women a false sense of assurance, possibly due to the complicating factor of GAHT.

"We are recruiting anyone who has an intact prostate where the cancer has spread to different parts of the body," said one of the LIBERTAS researchers, Neeraj Agarwal, MD, professor of medicine and senior director for clinical translation at the Huntsman Cancer Center in Utah.

"So we are not excluding anyone based on how they look. Second, [transgender] patients may have gotten androgen deprivation therapy or testosterone-lowering therapy in the past, and if they have prostate cancer, it may be more aggressive prostate cancer [because] the major driver was not there and they still had prostate cancer. So, do they have different biology?"

Agarwal speculated that they might respond differently to treatment compared to cis men with prostate cancer.

Another benefit of the study, Agarwal added, is that it will encourage investigators across the world to not exclusively use the word "men" when referring to people with prostate cancer. "We want to improve the awareness of transgender people, and we specify that this trial is transgender inclusive. And know many of these individuals are never diagnosed in a timely fashion or treated well. Anyone who has an intact prostate—and it doesn't matter how they look, how they dress, how they behave—the trial will include them. I think it is a major step forward."

The struggle for trans inclusivity in clinical studies

"The biggest story is we don't know enough, and that is specifically because there has been a willful lack of data collection about our [transgender] population," said Scout, PhD, MA, executive director of the National LGBT Cancer Network and member of the Johnson & Johnson prostate cancer patient advocacy steering committee. "So we are almost always left to hypothesize based upon the data points we have."

"Right now we know that trans women are at risk for prostate cancer, but do we know how the hormone interactions affect that risk for prostate cancer?" Scout said. "Trans women have a huge level of discrimination in our society in the first place, and I know way too many who don't even have routine access to health care, who would anticipate that... trans women are most often finding their

recruiting trans women

cancer much later than the rest of the population, and when they do so, they have very few treatment options, and their limited access to health care in the first place is probably going to further limit those options."

But Scout admitted that without the kind of data LIBERTAS can provide, that's still a theory. The goal should be, he said, to design clinical studies that account for all variables that affect health outcomes. "So if you are continuing to say, 'this medicine is going to work great with the people with this genetic combination, and all the people we tested on were cis, straight, white guys with this genetic combination,' that doesn't mean you can say in the general population… that this treatment will work well with them, because you've got other variables you haven't looked at."

Designing and conducting more inclusive studies requires extra effort and money for recruitment, plus a determination to do things differently, advocates say.

Recently the U.S. Food and Drug Administration (FDA) issued preliminary guidelines urging greater diversity in clinical studies. Though it didn't single out transgender or nonbinary people, trans advocates take this as a sign the tide may be turning toward greater inclusivity. If so, it's a change that's been a long time coming.

"We see an increased desire to include trans people in clinical trials largely due to long-term advocacy from the trans community demanding inclusion," said Eli R. Green, CSES, who uses the pronouns he and they, and is the founder and principal of Trans Affirming Training & Consulting and consultant on the LIBERTAS study.

"We also have more trans people and allies in the medical fields who are raising the question of why trans folks are not already being included, and how to change that. The FDA mandate is helpful, but without folks who are dedicated to understanding how their work impacts (or omits) transgender, nonbinary and intersex people, nothing much changes."

The lack of diversity in study design, he said, has its genesis in medical school. "We know that in medical school, most students never receive any formal education on human sexuality as a whole, let alone the experience of people who fall outside the gender binary. So, in many cases it literally never occurs to folks designing the studies to include transgender, nonbinary and intersex people in their work."

When it comes to clinical trials, there are two primary areas of need, he said. "First is that many cisgender folks have no idea what it is like to be a trans person trying to engage in medical care or related systems, so we help them to understand the additional barriers that transgender, nonbinary and intersex people face and identify skills and strategies for removing or mitigating those barriers.

"Second is better understanding how to fit transgender, nonbinary and intersex people into medical systems that are designed based on the idea that sex and gender are a binary," he said. For clinical trials, this means having guidance on things like how to interpret lab values or inclusion criteria that align with the study goals."

Green and other advocates see one barrier in implementing inclusive clinical trials: physicians and staff often not trained on how to engage with trans people in ways that are positive and affirming.

There are some recent data showing the extent of discrimination against trans and gender nonbinary people. Nearly one-quarter of respondents in the 2022 U.S. Trans Study reported that in the previous 12 months they did not see a doctor when they needed to due to fear of mistreatment. Of those who saw a healthcare provider within the last 12 months, nearly half (48%) reported having at least one negative experience due to being transgender, including misgendering, harsh or abusive language and even physical abuse or refusal to treat.

Such experiences lead to a mistrust of primary care physicians and discourage trans and gender nonbinary people from participating in trials. Scout said that researchers designing inclusive trials must take extra steps to combat "well-earned medical mistrust" by some populations.

"I'm talking with a lot of clinical trial sponsors, and they say they're not getting any referrals from the existing pool of enrollment sites," he said. "Well, you may be concentrating on enrollment sites and haven't done good work around combating structural discrimination with a lot of populations. So a lot of what we do is say, 'it isn't so complicated.' You need to take some steps to de-gender your clinical protocol. You need to then put out a modest amount of affirming information to say they're going to be safe."

> **'We are recruiting anyone who has an intact prostate where the cancer has spread to different parts of the body'**

Cultivating a diverse population for studies and clinical trials could not only lead to better science, but it also means more people will have better care and better treatments, Scout added. "They won't have to wait until five years after the medicine finally comes out. They will get the same kind of access the most privileged people in our society can as they sign up to be part of the clinical trials before the medicines are even on the street."

LIBERTAS has 90 locations throughout the U.S. To read the requirements for participating, **GO TO** clinicaltrials.gov/study/NCT05884398#participation-criteria. Eligible prospective participants can **EMAIL** Participate-In-This-Study@its.jnj.com for consideration.

PHOTO:

What we're learning about the six-month shot for HIV prevention

Insights on a game-changing drug from one of the lead clinicians testing lenacapavir as PrEP

BY **RICK GUASCO**

DR. COLLEEN KELLEY AT HIVR4P 2024, THE 5TH HIV RESEARCH FOR PREVENTION CONFERENCE, IN OCTOBER

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A six-month shot for preventing HIV has been making headlines lately because of how effective it's been proven (known as PrEP) in a series of clinical trials called PURPOSE. The drug, lenacapavir, is already FDA approved as HIV treatment, but only for people living with HIV who have few other treatment options left. The HIV prevention results have been so promising, lenacapavir's maker, Gilead Sciences, plans to apply for approval as long-acting PrEP in the U.S. and other other countries by year's end.

In June, it was announced that the PURPOSE 1 study had come to an early end because lenacapavir had an unprecedented 100% success rate in protecting cisgender women from HIV. Interim results from PURPOSE 2, among cisgender gay, bisexual and other men, transgender women, transgender men, and gender diverse individuals aged 16 years or older who have sex with partners assigned male at birth, found only two cases of HIV acquisition among the 2,180 participants, bringing that study to an end in September.

Colleen Kelley, MD, MPH, an assistant professor at Emory University, is one of the principal investigators in the PURPOSE 2 study. She's helped present the study's findings, including at the HIV Research 4 Prevention conference last October in Lima, Peru. She spoke with POSITIVELY AWARE in a phone interview about lenacapavir, the PURPOSE study findings and the future of long-acting treatment and prevention of HIV.

Kelley discussed the lessons learned about injection site reactions, other side effects and what can be done about them. Injection site reactions were reported by about half of the clinical trial participants—primarily pain or soreness where the injection was administered. This has been a complaint among people receiving long-acting injectable medications as well. The discomfort goes away after a few days and the occurrence with the injections has diminished over time. About half of the clinical study volunteers said they could feel a nodule, which is a concentration of the medication, referred to as a *drug depot*, which gradually dissipates.

POSITIVELY AWARE: What can providers start to do as they think about administering lenacapavir, in terms of counseling or patient education?

First, patient education. The nodule is the drug depot and is where the drug lives and will seep out into the body over time. And it's because of that nodule that we get this six-month protection from lenacapavir. So education of participants and patients around what to expect goes a long way [to address] their sensation of discomfort.

The other thing is that over time, with lenacapavir injections, we've learned a better injection technique. In some cases, we think that the injections were being delivered a little too superficially and not into the subcutaneous space [also known as the hypodermis; it's the deepest layer of skin and is located beneath the dermis]. And so quite a bit of education went on into the study sites to ensure that they were getting subcutaneous space injections, and that included the angle of the injection.

And then finally, we learned throughout the course of the trial that things like ice at the injection site, prior to the injection, significantly reduced the sensations of pain from injections. Overall, the take-home point is we got better at giving injections, and that is why there was a reduction in the reporting of injection site reactions over the course of the trial. Participants knew what to expect and things improved with respect to reporting those side effects. It's interesting that this has been seen with other injectable medications as well. It seems to be something that as people learn what to expect, as people learn how to give better injections, those things improve over time.

Will other underrepresented populations be studied, or how will they be considered for trials and testing?

People who inject drugs is the focus of the PURPOSE 4 study. That is another important population that has been left behind with respect to PrEP studies. [PURPOSE 3 is being conducted in U.S. among adult cis women.]

What about older people? Do we need to consider how lenacapavir works in people age 50 and older?

There was no upper age limit for inclusion in PURPOSE 2. There's no reason to think that there is an age concern with lenacapavir—74 was the age of the oldest person in the trial that got lenacapavir.

During PURPOSE 2 there were two cases of HIV diagnosed among study participants. Any thoughts about how this might inform HIV screening strategies for long-acting injectable PrEP?

That is a great question. We are waiting on more of the data around HIV diagnostics—how the cases [of HIV] were diagnosed. We know that injectable cabotegravir [another long-acting injectable medication, FDA approved for both HIV prevention and treatment] can cause what we call 'flickering' HIV tests and long-acting early viral inhibition syndrome, or LEVI syndrome [a condition that can occur in people who contract HIV while taking injectable cabotegravir as PrEP].

Can you talk a little bit about LEVI syndrome?

LEVI syndrome is what was seen with injectable cabotegravir. It stands for *long-acting, early viral inhibition*, meaning that when people received their cabotegravir injection, they were already HIV positive, but their diagnostic tests did not reveal that, or that people acquired HIV while they were getting injectable cabotegravir. Cabotegravir is such a potent medication that it actually suppresses viral replication. And so in those people, they basically had a kind of smoldering, low-level viral replication for a period of time, sometimes for weeks or longer. And because of that, their diagnostic tests, their antigen antibody tests, had very funky results, and sometimes even their viral loads had very funky results. They'd be positive on one check and then negative on the next. So, in some cases it was difficult to determine if someone who was on cabotegravir was seroconverting. And there were delays in a final diagnosis of HIV because of that effect. That LEVI effect has not been seen to date in lenacapavir. And I stress to date because it's so early in lenacapavir for prevention.

What about lenacapavir for treatment?

Lenacapavir has only been approved for salvage HIV treatment at this point in time—it's not approved for patients who are naïve to antiretrovirals. I will tell you, it is being increasingly used, though, in combination with Cabenuva, or cabotegravir + rilpivirine [the generic components that make up brand name Cabenuva], for people who are unable to adhere to oral regimens, and who may have some background HIV resistance in their virus. It kind of enables them to have an all-injectable regimen. We have a significant minority of patients who are not able to adhere to oral antiretrovirals, who, when given the opportunity, in the unusual cases where we've been able to get them to an all-injectable regimen, they do really, really well.

I know that you can't speak for Gilead, but would it not be logical to conclude that with lenacapavir being so successful at preventing HIV, you'd want to look at using it for broader HIV treatment, not just for heavily treatment-experienced people?

I have no idea what [Gilead is] thinking in that realm. I do know that there is hope that we could someday pair lenacapavir with another super-long-acting drug, such that it would allow for every-six-month injections for treatment. I mean, could you imagine if we could treat people with HIV with injections just twice a year? I think that is on the horizon. Like you said, I can't speak for Gilead, but I think that these long-acting injectables are really going to change the face of HIV treatment and prevention, and patients want them. Patients are clamoring for injectable agents. Not all patients, but a lot of patients are really, really interested in injectable agents.

Oral medications are being developed that would only need to be taken every two weeks, monthly, and even longer. Whether it's shots or pills, longer-acting seems to be the way things are going.

I'm not on the treatment side involved with any of those studies, but yes, you're absolutely right. The future is long-acting. Some people are needle-averse, and for those folks, they may elect to stay on an oral regimen. But there are lots of folks who are really excited about the opportunity to have an injectable regimen where they don't have to take pills on a regular basis.

What would you want to say to care providers about what's coming next with regard to lenacapavir, and maybe more broadly, about long-acting injectables?

Both on the treatment and prevention side, access to long-acting injectables has been very limited, and in the U.S., it's because of our complex insurance approvals and payer status that it is burdensome, I think, for clinics to take on injectables. It takes person power [staff hours]. It takes working with your billing departments, your prior approval departments; or if you don't have those departments, figuring out who on your staff is going to be able to do all that, and so it is a tremendous investment on the clinic side to figure out how to implement these. I do strongly believe that they are an important part of our future in HIV prevention and treatment. So, any effort that's made now to figure out how to implement them will ease implementation in the future, as we get more options for injectables, and as we get longer-acting options as well.

At the HIV Research 4 Prevention press conference you said, 'the researcher's greatest role is to join with advocates and the community to ask and demand that the drug is available to the people who need it most.' What does that look like? And how can researchers work collaboratively with community advocates?

I'm also the vice chair of the HIVMA [HIV Medicine Association]. We do a lot of advocacy and partnership with community to understand what the barriers are to access HIV treatment and prevention services, and work with our governmental agencies, work with our health care systems, advocate to our insurance companies to improve and ease access to these life-saving and life-changing medications. Our job as researchers is to listen to the patients that we see, the community, the advocates that we engage with, and raise our voice right alongside them—*I need these medications to treat my patients, and make them available to them without barriers.* It's absolutely our job to stand alongside and raise our voices as well.

Gilead has signed licensing agreements with six drug manufacturers that will allow the companies to make and sell a generic version of lenacapavir in 120 countries around the world and in Africa, but Latin America has been mostly left out, even though they're one part of the world that is seeing an increase in HIV cases. Latin America has come out short on that deal.

They do. Although I will say what I've heard from Gilead is that they are working on that. What they've released so far [the licensing agreement with six drug manufacturers] is just the first step. Now we need to hold them to that.

GILEAD SCIENCES

A recap of hot topics in HIV clinical sciences

BY **LARRY BUHL**

At IDWeek 2024 in Los Angeles, Alison Agwu, MD, professor of pediatric and adult infections at Johns Hopkins School of Medicine, highlighted wide-ranging clinical studies over the past year, some which are already impacting how clinicians provide HIV care across the continuum.

PrEP

Long underrepresented in HIV prevention research, cis women have become more visible in recent clinical trials with significantly favorable results this past year. Still, women face issues with PrEP uptake, adherence and persistence, said Dr. Agwu. They have Truvada (F/TDF) and Apretude (cabotegravir LA) as prevention options; however, Descovy (F/TAF) is not approved as PrEP for cis women and the dapivirine vaginal ring has not been approved in the U.S. “Additionally, we do need modalities that better fit cisgender women’s varied preferences and needs, and we need options for pregnant women,” she said.

Using the six-point face scale for pain, 43 (83%) of participants at week 4 and 38 (73%) at week 8 reported no or little pain from the injections

Gilead’s PURPOSE 1 trial, however, has shown great promise for lenacapavir (LEN) for cis women (see “Injectable lenacapavir 100% effective at preventing HIV in cis women,” SEP+OCT 2024). Presented at AIDS 2024 and in the *New England Journal of Medicine*, the study looked at the efficacy of LEN, an HIV capsid inhibitor given twice yearly, subcutaneously, compared to oral F/TAF for HIV prevention. Cis women between the ages of 16 to 25 who were not on PrEP and HIV-negative were randomized into groups given LEN subcutaneously every eight weeks with oral F/TAF placebo or TDF placebo. The second arm was F/TAF, oral daily versus subcutaneous LEN. The third arm was F/TDF. In the study, all participants were Black, 84% from South Africa and 16% from Uganda, and very few had ever been on PrEP. The results, which got a standing ovation at IAS 2024, showed zero infections in the LEN arm, or 100% efficacy. All PrEP arms were safe and well tolerated. Importantly, Dr. Agwu added, participants who became pregnant during the study were given the option to remain in the study, “with the idea of protecting people, not excluding them, through research.”

Results from the PURPOSE 2 trial, which looked at PrEP for cisgender gay, bisexual and other men, transgender women and transgender men and gender nonbinary individuals who have sex with partners assigned male sex at birth, had similarly stellar results for that population. There were substantial decreases in HIV acquisition, and only two HIV acquisitions in the LEN arm, and nine in the F/TDF arm, compared to the background incidents. Being a global study was significant, she said, as well as the fact that the majority of participants were non-white. “Only one in four had ever been on PrEP, and only one in four had no prior HIV testing. And there was a lot of stimulant use, which is a risk factor for HIV acquisition.”

“We need expansion in prevention strategies, period,” she said, noting that 1.3 million individuals acquired HIV in 2023 across the world, including 30,000 in the U.S. In early October Gilead announced licensing agreements with six drug companies to produce and sell a generic version of lenacapavir in 120 countries, including in Africa; however, many countries in Latin America, one region of the world that is seeing an increase in HIV, were left out of the agreements.

Long-acting injectables (LAIs) for treatment

Results from MOCHA (More Options for Children and Adolescents) were presented at CROI 2024 in March. MOCHA, a multi-center, open label, non-comparative study, part of IMPAACT 2017 (International Maternal Pediatric Adolescent AIDS Clinical Trials), looked at injectable cabotegravir (CAB) for adolescents 12–17 years, a group known to be less likely to adhere to antiretroviral treatment (ART), across the U.S. and several countries, including Thailand, Botswana and Ghana.

In results from the first cohort, published in *The Lancet* this past summer, 55 participants who remained on their background combination antiretroviral therapy were started with injectable CAB (30) or oral rilpivirine (25). Using the six-point face scale for pain, 43 (83%) of participants at week 4 and 38 (73%) at week 8 reported no or little pain from the injections, and a single (2%) participant for each week rated the pain at one of the two highest pain levels.

Results from cohort two, presented at CROI 2024, included 44 rolled over from the first cohort, with an additional 100 new enrollees. In this phase, participants stopped oral ART and went on injectables. This group had a median age of 15,

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about half were cis female; three out of four participants were African American. The vast majority (92%) had acquired HIV perinatally. The 48-week data presented at AIDS 2024 showed no unexpected safety events and virologic suppression was maintained. Participants cited convenience and, to a lesser extent, stigma reduction, as reasons they preferred long-acting injectables (LAIs). “Nobody wanted to go back to oral ART,” Dr. Agwu said.

IMPAACT 2036 will test long-acting injectables in children ages 2–12 years, she said, and IMPAACT 2040 will study injectables for pregnant women, “so more options to assure people can maintain viral suppression.”

Results from the LATITUDE (Long-Acting Therapy to Improve Treatment Success in Daily Life) study were presented at CROI 2024. The study looked at participants with poor viral response despite being on oral ART for more than six months, or oral ART non-adherence for more than six months. The median age was 40, and about 20% were under the age of 30. Significantly, 26% were over the age of 51, showing the “silvering” of the HIV epidemic, she said. At 52 weeks the study showed significantly fewer virologic failures (7.2%) in the CAB arm versus 25% failure using the oral standard of care.

Maintaining health with ART and beyond

Dr. Agwu acknowledged a 2024 report which supported breast and chest feeding choices for people living with and with a greater chance of acquiring HIV, which follows similar guidelines from the World Health Organization and the Centers for Disease Control and Prevention (CDC). “This is critically important because people continue to be stigmatized and this is an additional tool to be able to use to push back from that.”

For adults with perinatally-acquired HIV, the good news is that rates have been decreasing, and mortality in this group has declined. However, because the majority of people who acquired HIV perinatally are older than 25, and “have unique aging profiles and comorbidities that we have yet to understand, we need to assess what and how to address this population,” she said. A 2024 study of non-AIDS-defining comorbidities among young adults with perinatally-acquired HIV found that by the age of 30, about one in three had type two diabetes, about half had hypertriglyceridemia (high levels of fats that provide energy to the body, but are a risk factor for cardiovascular disease) and one in three had chronic kidney disease. “So, significant cumulative incidence of non-AIDS-defining conditions.”

This is important in light of updated guidelines from the U.S. Department of Health and Human Services (HHS) on statin therapy for adult and adolescent people living with HIV. “The findings from REPRIEVE [a study to reduce heart disease in PLWH] related to the higher absolute benefit of statin therapy among those with greater [atherosclerotic cardiovascular disease, ASCVD] risk informed the panel’s decision to recommend the use of at least moderate-intensity statin therapy with a strong recommendation for those with 10-year ASCVD risk score equal to or greater than 5% to less than 20%,” state the new HHS guidelines.

Advocacy and funding priorities: Tennessee as a cautionary tale

In a segue to advocacy and money, Dr. Agwu warned the audience that the HIV community is facing continuous attacks on funding, meaning “the progress we’re making with all the things we’re talking about could be at risk.”

To emphasize this threat, she pointed to research published in the June 2024 issue of *Clinical Infectious Diseases* that showed how Tennessee’s new policy of shifting funding for HIV prevention could lead to more illness, more deaths and higher costs.

In January 2023, the state rejected $6.2 million in funding from the CDC for prevention tools like HIV testing kits, condoms and PrEP, which had been prioritized for groups who are seeing higher rates of HIV, such as men who have sex with men, transgender women, people who inject drugs and heterosexual cisgender Black women. Instead, Tennessee planned to reallocate funding for HIV testing to three other groups: first responders, pregnant women and survivors of sex trafficking—populations that represent a tiny population of people vulnerable to acquiring HIV.

Massachusetts General Hospital analyzed the effects of this reallocation, using a computer-based simulation model called Cost-Effectiveness of Preventing AIDS Complications (CEPAC) to predict outcomes statewide.

The team of researchers found that shifting funding away from CDC-prioritized populations would result in an additional 166 HIV transmissions, 190 deaths and 843 life-years lost over a decade. Led by Ethan Borre, MD, the researchers also determined that the change would increase costs to the state by 1,300%, or $4.1 million. In a press release, Borre said Tennessee’s HIV funding reallocation would “worsen existing disparities with minoritized populations experiencing a lion’s share of increased deaths.”

“What you saw in this analysis would be decreased virological suppression, decreased linkage to care and fewer individuals biologically suppressed, and would prevent zero HIV transmissions in the Tennessee priority populations,” Dr. Agwu said. From 2018 to 2023, Tennessee reported a 40% increase in HIV transmission among people ages 15–19 years. “So we have to match what’s happening on the ground with our funding,” she said.

An epidemiological study released in May 2024 by the Tennessee Department of Health underscored this analysis, stating that that non-Hispanic Black people faced the highest burden of HIV across all gender and age groups in the state, and that 14% of new diagnoses occurred among people who inject drugs.

She ended on a hopeful note, telling participants to be calm but vigilant, especially in the face of proposals from Republicans in the U.S. Congress to slash hundreds of millions from federal HIV programs. “Please tell Congress to save HIV funding.”

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Managing substance use disorders and HIV

BY **LARRY BUHL**

One of the many issues that HIV health care providers should consider to improve outcomes for patients is identifying methamphetamine use and how to help patients reduce or stop their use, according to presenters at one panel during IDWeek 2024 in Los Angeles.

Jennifer Fulcher, MD, an associate professor at the David Geffen School of Medicine at UCLA, explored the epidemiology of stimulant use among people living with HIV (PLWH) and explained how stimulants, especially methamphetamine, exacerbate inflammation in HIV and why the risk of acquiring HIV among people who use meth goes beyond the behavioral effects of the drug.

The impact of meth

The strong correlation between meth use and new HIV cases isn't the only cause for concern, Fulcher said. Methamphetamine use leads to worse HIV-related outcomes.

"There's less engagement in care, there's less ART [antiretroviral treatment] adherence, increased ART resistance, disease progression, CD4 decline and increase in HIV-associated neurocognitive disorders [for PLWH who use meth]," she said. "And what has been reported in many studies is decreased viral suppression, and at least two different studies have found that [decreased viral suppression] still occurs even when somebody is taking ART."

'The drug is to blame here,' she said. 'It's not just the behavior.'

—**Jennifer Fulcher, MD**

In anyone, meth use increases the chances of developing mental health disorders, neurocognitive disorders, oral health problems and cardiovascular risk, including increased pulmonary hypertension. For PLWH, meth use brings a host of other complications, including increased HIV transmission and replication in certain cells, and increased systemic inflammation and immune activation, which causes a feedback loop of inflammation-related HIV replication. Fulcher pointed to a 2018 study that showed an increase in rectal inflammatory cytokines [small proteins that are crucial in controlling the growth and activity of other immune system cells and blood cells] following recent meth use, which was true regardless of HIV serostatus, age, sex and receptive anal intercourse.

"So, by way of increasing this mucosal inflammation, inducing barrier damage and attracting and activating target cells, that makes it a much more risky area and risky time for HIV transmission," she said.

Also adversely affecting the long-term health of PLWH is the drug's effect on the gut microbiome (which can affect users regardless of their HIV status). But because meth use in PLWH contributes to ongoing gut inflammation, Fulcher said, it can contribute to chronic immune activation and systemic inflammation that contributes to many HIV-related comorbidities.

Methamphetamine can decrease blood-brain barrier function, which can increase neuro inflammation that then feeds into immune cell activation, viral replication and progression of neuroAIDS (any neurologic condition stemming from HIV) and HIV-associated neurocognitive disorders, she said.

These negative outcomes occur even when a person living with HIV is taking ART and attending their appointments. "The drug is to blame here," she said. "It's not just the behavior."

Nearly 10 million people in the United States used stimulants in the past year, estimates the National Survey on Drug Use and Health. Fulcher noted that substance use in general is more prevalent among sexual minority populations, both men and women, and highly prevalent among men who have sex with men and in PLWH. "The estimated stimulant use among people living with HIV is between five and 15%, which is markedly higher than the general population," she said. Drawing an association between methamphetamine and HIV acquisition, Fulcher pointed to the results of an online cohort study of about 5,000 sexual and general minority persons which found that methamphetamine use accounted for up to one-third of new HIV diagnoses.

Is there a role for HIV clinicians?

Fulcher said HIV clinics can take an active role in weaning patients off methamphetamines, but must do so with care, in a non-stigmatizing and non-judgmental way, with an understanding of the context of stimulant use.

Any substance use treatment, even if it's not specifically for stimulant use, could be helpful, Fulcher said. In Los Angeles-based cohort research, the Mstudy, which looked at methamphetamine use trajectories, researchers found that people who received any type of substance use treatment—for tobacco, alcohol, opioids or any combination of the above—reduced their methamphetamine use by almost half. "Engaging people in any kind of treatment or recovery could be beneficial," she said.

Even switching the type of ART could help harm reduction. A 2023 demonstration project from Zuckerberg San Francisco General Hospital's Ward 86 HIV clinic, where about a third of the population actively used stimulants, found that switching to long-acting ART significantly improved viral suppression, though it didn’t conclude why.

Fulcher said that abstinence from different drugs provides better viral suppression; especially with methamphetamine, even a reduction in the frequency of use can have a significant effect on viral suppression, as well as other health outcomes. “Encouraging patients to reduce the frequency of their use can have a lot of benefit,” Fulcher said.

Treatment options for methamphetamine use

Fulcher discussed several options for health care workers to treat people who use meth, including contingency management and medication.

Contingency management is a behavioral intervention with motivational incentives, such as gift cards, often with escalating value for positive behavior that would reward evidence such as a negative urine drug screen for meth users. Multiple randomized clinical trials, she said, support the efficacy of contingency management, either alone or in combination with other strategies.

Contingency management does have challenges, she noted. “It takes additional time and staffing, because you need the patients to come back, either weekly or every other week. And especially if [a clinic is] using federal funds, there’s financial limitations on how much a patient could receive as a reward, so that can really hinder your ability to provide a truly motivational reward.”

Still, if implemented well, contingency management can improve HIV-related outcomes. A pilot study from the University of California at San Francisco combined contingency management for substance use disorder and treatment of infectious complications. The study, conducted in an acute care setting, used a “fishbowl strategy”—every time patients met a goal, they were allowed to reach into a fishbowl to draw a prize.

“[Patients] had an incredibly high rate of antibiotic completion, a high rate of abstinence from drug use,” Fulcher said. “You can imagine how a strategy like this could be used also in the HIV clinic to incentivize attending appointments and ART adherence.”

Two medications, naltrexone, in combination with bupropion, as well as mirtazapine, could be used to manage substance use.

“Bupropion can be beneficial for people who enjoy the weak stimulant effect,” Fulcher said. “It also is FDA approved for smoking cessation, so if you have a patient who also uses tobacco, this could be a great option. Naltrexone is FDA approved for alcohol and opioid use disorder, so it can be used to co-manage those, though it can increase risk of opioid overdose. Mirtazapine, an FDA approved antidepressant, can be beneficial in patients with mood disorder, but has side effects of weight gain and sleepiness.”

A 2021 study published in the *New England Journal of Medicine* found that for people with moderate to severe meth use disorder, treatment with a combination of extended-release naltrexone plus daily oral extended-release bupropion over a 12-week period “resulted in a higher response than a placebo.”

Two randomized clinical trials, both in men who have sex with men, found that mirtazapine resulted in a decrease in methamphetamine use as secondary outcomes. “[Researchers] also looked at sexual risk behaviors, which they defined by varying measures, and found a decrease in that as well as no adverse effects,” Fulcher said.

Treating the whole person in a substance use clinic

In the same session, Hermione Hurley, MD, an associate professor at the University of Colorado, made a case for a “concurrent context of care” for PLWH who use stimulants and other substances. Providing examples from the Denver Center for Addiction Medicine, a public health use disorder (PHUD) clinic, Hurley said the mission is to provide low barrier to access and counseling, while improving engagement for HIV care. “There is a lot of stimulant use disorder in Colorado,” she said, and that patients do not need to be sober to seek HIV care at the clinic.

Hurley began with a plea to attendees: never withhold HIV meds for people actively using substances. “Please give people the medicines,” she said. “It both invests in them in the long-term, and they will be successful,” she said. “This is really a ‘no wrong door’ model.”

Decreasing stigma with person-first language and care is crucial to serve this population, she added. “We made a de-stigmatizing name, PHUD, and that means you can check in at the front desk and know that you’re not going to be judged in the hallway,” she said. “You’re just coming to the other ID [infectious disease] clinic and all the other things that people would normally do for HIV. It doesn’t identify you clearly as someone who has a concurrent substance use disorder.” But they will have access to clinic support staff, patient access specialists, ID social work, behavioral health and ID medication management.”

“We co-locate with other kind of really high-value colleagues and clinics that we use as part of our Ryan White funding,” she said.

Hurley’s second suggestion for substance use clinics that aim to treat the whole patient: standardize intake labs for hep A, B, C and HIV. “One draw and you’re done. You’ve really got to grovel to your lab directors. But boy, this makes a huge difference,” she said.

‘One draw and you’re done. You’ve really got to grovel to your lab directors. But boy, this makes a huge difference’

—Hermione Hurley, MD

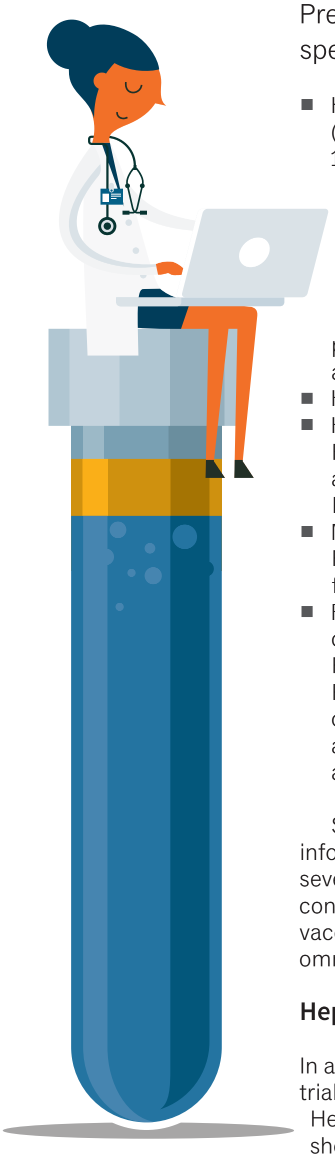
“In a large urban setting where I have syringe service programs, I am finding a lot of hepatitis C [and finding] hepatitis B cases among people injecting methamphetamine who are older than sort of 35 to 60, too old to have received childhood vaccinations.”

Hurley also recommended that ID generalists or specialists with the inclination should help out in a rural community. “Rural areas [are] where I’m seeing more new diagnoses associated with substance use, because it is hard for people to drive to a syringe service program.”

And wherever they practice, professionals should consider the patient’s butt, Hurley said, noting the high risk of anal cancer for PLWH. “Some of the people that will always stay with me actually had terrible anal cancers, and they never felt that they could tell me after almost a decade.”

Vaccine recommendations for people living with HIV

BY **LARRY BUHL**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There are certain vaccine considerations for people living with HIV (PLWH), which was the topic of one presentation at IDWeek 2024 in Los Angeles. Melanie Thompson, MD, past principal investigator of the AIDS Consortium of Atlanta, shared the latest immunization schedule from the Centers for Disease Control and Prevention (CDC), which includes notes specifically for PLWH:

- Herpes zoster (Shingrix): Ages 18 and older, both doses, with no CD4 criteria. People without HIV are recommended to get Shingrix to prevent shingles at age 50.
- HPV: Three doses.
- Hep A: Recommended for all PLWH, regardless of CD4 count.
- Meningococcus: Recommended for all.
- Respiratory syncytial virus (RSV): Recommended for PLWH ages 75 and older, and PLWH ages 65–74 with advanced HIV.

She had additional information about several other conditions where vaccinations are recommended for PLWH.

Hepatitis B

In a recent clinical trial, a new vaccine, Heplisav-B, was shown to be highly effective for PLWH. In the first arm of the study, two doses achieved a response in nearly all participants, and after three doses 100% had a seroprotective response. In the second arm of the trial, Heplisav-B was superior to other hep B vaccines for PLWH who had previously not responded to an older hep B vaccine, including people with low CD4 counts. The recommendation for PLWH, Dr. Thompson said, is two doses [of Heplisav], one month apart, but it should not be given to anyone who is pregnant, due to insufficient safety data.

Mpox

The CDC recommends vaccination with a two-dose Jynneos vaccine series. It's especially important for adults at risk for serious impacts from mpox to get both doses—this includes gay, bisexual and other men who have sex with men, transgender and nonbinary people who had a new diagnosis of gonorrhea, chlamydia or syphilis in the past six months or who had sex in a commercial sex venue or in association with a public event.

Dr. Thompson said PLWH must be prioritized for mpox vaccination and treatment with a racial equity approach. Of those who died from mpox, most had HIV, mostly with very low CD4 counts, she said, noting that the vast majority of mpox deaths in the U.S. were among Black men.

Pneumococcus

Studies have shown a much higher risk of severe pneumococcal disease in people with HIV compared with people without HIV, especially those with high viral load and/or low CD4 counts, and Thompson recommended the newest pneumococcal vaccines, PVC15, PVC20 or PVC21, for PLWH.

COVID-19

COVID-19 is still with us, even though the official pandemic emergency has ended. Even a mild infection can lead to long-term health consequences, usually lumped together under the umbrella of "long COVID." Dr. Thompson said that people with HIV and low CD4 counts do badly with COVID. "They're at higher risk for serious disease and death for long COVID, for rapid viral evolution, and [PLWH] may be more likely to get re-infected." Vaccination helps mitigate the risks, and people with advanced HIV, specifically a low CD4 count, should get a full series of vaccines, three mRNA shots or two doses of Novavax. If they're completely vaxxed, they should be boosted with the updated vaccines at least once a year.

Cancer

Cancer is a leading cause of death for people with HIV, particularly non-AIDS-defining cancers like lung, anal, prostate and liver. Vaccinating against HPV and hepatitis B prevents certain cancers, and there is no age limit for cervical Pap screening for people with HIV, Dr. Thompson added.

The latest International Neoplasia Society consensus guidelines recommend screening for men who have sex with men and for transgender women with HIV at age 35 and at age 45 for all other PLWH as well as men who have sex with men and transgender women without HIV. The guidance recommends an annual digital rectal exam, regardless of whether high-resolution anoscopy is available.

Contraindicated vaccines

Dr. Thompson noted vaccines that PLWH should not get, including the live attenuated influenza vaccine and the live attenuated smallpox ACAM 2000 vaccine, which is also now used for mpox. If the CD4 count is less than 200 or HIV is uncontrolled, PLWH should not get live attenuated typhoid vaccine or MMR or varicella or yellow fever vaccines, she said.

"Remember that the response to vaccines may be low when CD4 is low, but it improves when CD4 rises," she added.

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HIV in the Latine community—a bigger, deeper vision

Advocates at USCHA 2024's closing session call for greater collaboration and a wider scope in the face of social and political challenges ahead

BY **RICK GUASCO**

The need for deeper and broader collaboration among HIV advocates and organizations was a key point in the closing plenary session of the U.S. Conference on HIV/AIDS held in New Orleans that concluded on September 15.

With its bilingual title, *The South Calls, We Respond; El Sur Llama, Nosotros Respondemos*, the plenary featured **Judith Montenegro**, program director of the Latino Commission on AIDS' Latinos in the South initiative, with a panel moderated by **Will Ramirez**, director of public policy and advocacy at the Southern AIDS Coalition.

Judith Montenegro

"I started working at the commission over 10 years ago in their Latinos in the South program," Montenegro said, "and at the time, I was a baby organizer, traveling across nine southern states asking, *Is this available in Spanish?*, a phrase I still have to repeat today. For many of us in the South, the South is full of repetitions—of histories repeated, of lessons relearned and of remembered strategies.

"For Latinx communities in the South, some states became a new destination," she continued. "For others, it's always been home, and for some, migrating to the South is also a homecoming of land stolen or of borders imposed. The South has shaped me, challenged me, been my teacher, nourished my hopes and dreams for my people and this place that we call home.

"Throughout my years in the field, over the time spent building a life in North Carolina, it's been a gift to witness not only the growth of my Latinx community throughout the region, but to also see so many Southern Latinx colleagues increase in number each year. We are slowly chipping away at the physical and metaphorical walls built to keep us out yet and still, we have ways to go... And while the South may put out a welcome mat and hand you a glass of sweet tea, it would also tell you to roll up your sleeves and get to work."

A succession of Latinx/Latine queer folk introduced themselves to the audience, sharing a part of their lives. Among them:

"I'm **Umberto**. I am a volunteer from Atlanta, for a community-based organization called Latino LinQ in Atlanta," said the first speaker, an immigrant Latino gay man. "In 2008 I was given this life-changing diagnosis. Since then, I have gained a community that embraces me, for all of me, but I have also lost friends who should still be here. They propel me to keep pushing for equity in HIV services for everyone in my community."

> 'We deserve to be seen, heard, lead and have a seat—not at one table, but all the tables.'

Making the case for language justice, **Carlitos Xavier Díaz Rodriguez**, an artist activist in residency and HIV justice program lead artist at QLatinx in Orlando, spoke in a mix of Spanish and English.

"Necesitamos acceso y educación—para personas que se parecen a mí—con recursos en nuestra idioma," he said. "We need access and education—for people who look like me—with resources in our language."

Adonis Gutiérrez

As a trans man, **Adonis Gutiérrez**, co-founder and CEO of Under the Umbrella, a nonprofit serving trans and gender nonconforming folk in South Texas, said he sees firsthand the disparities Latine people face in PrEP, HIV testing and healthcare, and how stigma exacerbates these gaps.

The District of Columbia and 19 states have laws that allow undocumented immigrants to obtain a driver's license—of those, only Maryland and Virginia are in the South, said **Jean Hernandez**, program coordinator for AIDS Alabama's El Centro de Acceso para Latinos de Alabama/The HUB wellness clinic. Without a state ID or Social Security card, undocumented immigrants are often unable to access medical care or social services, leading to health disparities and social isolation.

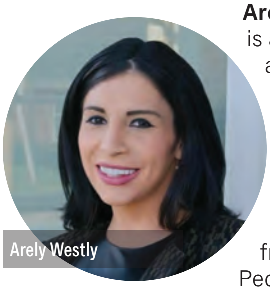
"We deserve to be seen, heard, lead and have a seat—not at one table, but all the tables, because representation is important to reach equality," Hernandez, a "proud Latina and Boricua [Puerto Rican]," said.

Miguel Garcia

Miguel Garcia, advocacy manager for the Southern AIDS

Coalition, recounted how he was racially profiled and pulled over. Border patrol falls under federal jurisdiction, but SB-4 is a state law that empowers Texas police to arrest anyone illegally crossing the Mexico border. Six Texas state trooper vehicles surrounded Garcia's car on his 56-mile drive to finalize paperwork for Ryan White services. A U.S. citizen, Garcia was told by one officer he was lucky that he was following the law.

"Imagine what is happening to our undocumented brothers and sisters," he said.


Arely Westly

Arely Westley is a longtime advocate for immigrants, Latinx and LGBTQ+ communities. Originally from San Pedro Sula, Honduras, she works with organizations in New Orleans and nationwide to uplift LGBTQ+ youth, stop abuse in U.S. Immigration and Customs Enforcement (ICE) detention facilities and expand access for migrants to support services. She is a member of the Southeast Dignity Not Detention Coalition, a community advisory board member for the Tulane Total Health Clinic and recently joined the board of directors of Asheboro Latinxs Services and Alianza Trans Latinxs. Earlier this year, she received the Robert F. Kennedy Human Rights Award.

"When I first got the Robert F. Kennedy Human Rights Award, I made a clear statement that this award does not only belong to me, it belongs to all the intersectional communities that I represent as a Honduras-born trans woman who grew up in Louisiana," she said. "I'm not only representing my trans Latina community, I'm also representing the Latinx community in the whole country and the whole migrant community."

She added, "We need to start working together for real, because it's nice that we see each other every year at this conference, but when each one of us goes back to our towns, we don't hear [from anyone]. We need to stay connected and to actually be in solidarity with each other in order to be able to build power. We can build power together."

Aubri Escalera is co-founder of Atlanta-based Trans Power in Diversity and the LGBTQ+ liaison for Georgia 58th District state representative Park Cannon.

"As a trans Latina immigrant, I am here to advocate, empower and build collective power," she said. "Southern power is trans power. Oftentimes, we have the tools to thrive but lack the credentials to work. Inclusive language is important, especially for our 50+ immigrant community living with HIV. By bridging legislative efforts with grassroots organizations and health centers, we can create a future where community feels valued, protected and free."

Gabriella Rodriguez, executive director of QLatinx, pointed out the threats posed in proposed state laws throughout the U.S.

"Over 530 harmful anti-LGBTQ bills have been introduced nationwide, with 251 of those targeting us here in the South," she said. "These aren't just numbers. They represent a real threat to our safety, our mental health, our emotional and physical health, and our very existence, *pero* I've also seen the strength in the face of adversity, especially in the aftermath of tragedies like Pulse [the fatal nightclub shooting in Orlando].

'It is not enough to simply have people who speak Spanish, they must also understand the language of HIV prevention and be able to communicate that message effectively to our community.'


Christopher Cuevas

A nonbinary, indigenous Latino who was born and raised in the Deep South, **Christopher Cuevas** is senior program manager at AIDS United. "Over the next 30 years, Latines are projected to be nearly 30% of the total U.S. population, making us the largest ethnic or racial minority group in the nation," they said. "We also represent nearly 45% of those without health insurance.

They continued, "If every state in the nation expanded Medicaid, the percentage of uninsured Latines would drop by over 16%. We must do everything in our power to ensure every person in this nation can afford quality and affirming health care."


Andres Acosta Ardila

"There are three things that we need to keep in mind in order to improve health equity and HIV prevention in Latinx communities in the South," said **Andres Acosta Ardila**, director of community relations for Pineapple Healthcare in Orlando. "The first is a need for representation and language justice. We know that when organizations that serve our communities have individuals in all levels of the organization that look like us, speak our language, it leads to [better] health outcomes.

"But we also need to be mindful of understanding that [Spanish speaking] individuals need support with medical language," said Acosta Ardila. "It is not enough to simply have people who speak Spanish, they must also understand the language of HIV prevention and be able to communicate that message effectively to our community. That means organizations have to be willing to invest in both training and paying those people properly so that they can do this work.

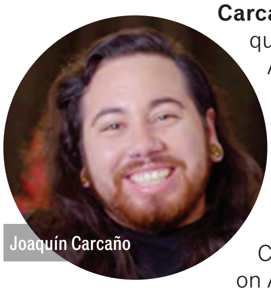
"The second is to create a network of support that goes beyond just HIV services. I am grateful to work for Pineapple Healthcare, which is a 340B [organization], and is able to use those resources not just to ensure that individuals have access to insurance and medication, but also transportation services, mental health care and housing referrals for case management. Not only that, but we fiscally sponsor organizations like Abrigado Corazones which collects clothing, hygiene products and some mobility devices and items for children and distributes them to the community, especially the immigrant community... We partner and have sponsored Aguilar Salud, which handles linkage to care for Latinx individuals, and has increased our ability to use telehealth services to link Latinx individuals in rural areas to care. These networks of support are crucial in ensuring our community is linked and stays in care.

"It is not enough to provide HIV services. We have to be willing to collaborate with each other to actually form these networks of support.

"Finally, organizations need to not be afraid to take a stand. We're mindful of our 501(c)(3) [nonprofit] status, but that is not an excuse to not advocate for what is right. Our CEO, Ethan Suarez, openly spoken about the need for providing healthcare services for our undocumented community, and in the face of the ban on trans healthcare, we took all possible steps to ensure that our trans *familia* was able to access care without facing disruption in services. It's crucial to understand that our organizations represent hope and a lifeline to many, and we cannot stay silent as our Latinx and LGBTQ communities are under attack, especially when those attacks affect their health care. We all have to take a stand and stand up for what is right."

'I am a person who used drugs, and I am in recovery, and I hold the role of director of community relations in my organization. This is important because we often talk about people who use drugs as a priority population, but we don't take the steps necessary to hire them, and by doing this, we're doing a disservice to our community.'

A recent graduate of the University of North Carolina at Chapel Hill School of Nursing, **Joaquín Carcaño** is a queer Mexican American trans man who directs Southern health policy at the Latino Commission on AIDS.


Joaquín Carcaño

"The highest rates of new HIV transmissions in Central Florida are among the Latinx community, and we know that the highest co-occurring condition in Central Florida for people living with HIV is substance use," he said. "Harm reduction is a lifeline for those most marginalized and stigmatized in our community, and the principles behind harm reduction need to be applied to all of our outreach and prevention efforts. The key is to understand that we have to meet people where they're at. It is not enough just to offer prevention methods if we don't carefully consider the needs of people who use drugs. In the Latinx community, we see compounding stigma from being at the intersection of Latinx identities, HIV status and drug use.

"I've seen all of those and have experienced all of those stigmas myself, and that stigma keeps people out of care," he continued. "The more we focus on harm reduction efforts that destigmatize drug use, the more that individuals who are struggling can feel safe to access care. There is also a need for Latinx communities, especially those of us who identify as people who use drugs or people in recovery, to join planning councils… I want to point out that I am a person who used drugs, and I am in recovery, and I hold the role of director of community relations in my organization. This is important because we often talk about people who use drugs as a priority population, but we don't take the steps necessary to hire them, and by doing this, we're doing a disservice to our community.

"The media has this narrative that is often wrong or not a complete picture," he continued. "We think of trans care as, *here's a surgery, here's an injection*. We don't talk about the impact that has on a person and their body and their life, and that's what's really at the depth of this work, at the depth of our access to care. I grew up not knowing what I was suppressing, not knowing what I had hidden away, and unlocking that, and knowing what could exist for me, what possibilities I could access, was groundbreaking for me. And I think a part of trans care is saying, *I have a whole other life to live. I have a fullness I haven't yet accessed.*

"Restrictions on anti-trans care [are] really hyper-focused on youth right now. What is really happening is they say, *you will not be allowed to be a trans adult—full stop. You will not be allowed to exist as a trans adult. We will deprive you of that.* Those consequences are huge upon the mental health and wellbeing of our community, of our youth. They say they're trying to 'protect' our youth, but these are the same people who will tweet *thoughts and prayers* after a school shooting; that's not protecting our youth.

"The Texas Attorney General has made requests to Washington, D.C. and Georgia for trans patient records of Texans who have fled their state," he said. "He's finding loopholes in medical privacy records to get data of former Texans who have fled their state who are trans. The implications of that are huge. We talk about authoritarianism and fascism after this election—it's here, and we need to do something about it. It's happening. It's active. Why does he need this information? … [In Alabama, where an anti-trans youth care law was passed,] it was a felony ban against providers. If you were to provide trans care, you will be hit with a felony. They are threatening to revoke medical licenses, of putting doctors in prison. So what do these doctors do? We're seeing doctors flee the South. What does that mean for our entire public health system, the providers who provide trans care are primary care providers and endocrinologists who also work with patients with diabetes. Think about the implications of our entire public health system. We're increasing our loss of primary care providers and providers who can care for diabetes management. That is huge. That's where our cross-solidarity movement needs to come in. [It affects the work of] public health work, of retainment, of our rural healthcare. Who is going to be affected? All of us. It's not just trans care."


Will Ramirez

Will Ramirez, the panel's moderator, teased an upcoming Southern States Manifesto, 2024 Update. "This report is the culmination of work that has taken place over two years that we feel tells a comprehensive story of HIV in the South." When released, the report will be available at southernaidscoalition.org.

ISTOCK

El VIH en la comunidad Latine: Una visión más amplia y profunda

Los defensores en la sesión de clausura de USCHA 2024 piden colaboraciones y un alcance más amplio ante los desafíos sociales y políticos que se avecinan

ESCRITO POR **RICK GUASCO** • TRADUCCIÓN POR **CHRISTINE SCOVILL**

La necesidad de una colaboración más profunda y amplia entre los defensores y las organizaciones del VIH fue un punto clave en la sesión plenaria de clausura de la Conferencia de Estados Unidos sobre el VIH/SIDA (USCHA, por sus siglas en ingles) celebrada en Nueva Orleans y que concluyó el domingo 15 de septiembre.

Con el título bilingüe de El Sur Llama, Nostres Respondemos, la plenaria contó con la participación de **Judith Montenegro**, directora del programa de la iniciativa Latinos en el Sur de la Comisión Latina sobre SIDA, con un panel moderado por Will Ramírez, director de políticas públicas y defensa de la Coalición del Sur contra el SIDA.

Judith Montenegro

“Comencé a trabajar en la comisión hace más de 10 años en su programa Latinos en el Sur”, dijo Montenegro, “y, en ese momento, era una organizadora joven, viajando por nueve estados del sur preguntando, ¿Está disponible esto en español?, una frase que todavía tengo que repetir hoy. Para muchos de nosotros en el Sur, el Sur está lleno de repeticiones: de historias repetidas, de lecciones reaprendidas y de estrategias recordadas.

“Para las comunidades Latinx del Sur, algunos estados se convirtieron en un nuevo destino”, continuó. “Para otros, siempre han sido su hogar, y para algunos, migrar al Sur también es un regreso a casa, a una tierra robada o a fronteras impuestas. El Sur me ha formado, me ha desafiado, ha sido mi maestro, ha alimentado mis esperanzas y sueños para mi gente y este lugar al que llamamos hogar.

“A lo largo de mis años en el campo, durante el tiempo que pasé construyendo una vida en Carolina del Norte, ha sido un regalo presenciar no solo el crecimiento de mi comunidad Latinx en toda la región, sino también ver a tantos colegas latinos del sur aumentar en número cada año. Poco a poco estamos derribando los muros físicos y metafóricos construidos para mantenernos afuera, pero aún tenemos mucho camino por recorrer... Y aunque el Sur puede ponerte una alfombra de bienvenida y ofrecerle un vaso de té dulce, también le diría que le arremangue y le ponga a trabajar”.

Una sucesión de personas latinas LGBTQ+ se presentaron ante el público y compartieron una parte de sus vidas. Entre ellos:

“Soy **Umberto**. Soy voluntario de Atlanta, de una organización comunitaria llamada Latino LinQ en Atlanta”, dijo el primer orador, un inmigrante latino gay. “En 2008 me dieron este diagnóstico que cambió mi vida. Desde entonces, he ganado una comunidad que me acepta, por todo lo que soy, pero también he perdido amigos que todavía deberían estar aquí. Ellos me impulsan a seguir luchando por la equidad en los servicios de VIH para todos en mi comunidad”.

Adonis Gutiérrez

“Merecemos ser vistos, escuchados, liderar y tener un lugar, no en una mesa, sino en todas las mesas”.

Al defender la justicia lingüística, **Carlitos Xavier Díaz Rodríguez**, artista activista en residencia y artista principal del programa de justicia del VIH en QLatinx en Orlando, habló en una mezcla de español e inglés.

“Necesitamos acceso y educación—para personas que se parecen a mí—con recursos en nuestro idioma”, dijo.

Como hombre trans, **Adonis Gutiérrez**, cofundador y director ejecutivo de Under the Umbrella (Bajo el paraguas), una organización sin fines de lucro que ayuda a personas trans y no conformes con su género en el sur de Texas, dijo que ve de primera mano las disparidades que enfrentan las personas latinas en la prevencion de VIH con PrEP, las pruebas de VIH y la atención médica, y cómo el estigma exacerba estas brechas.

El Distrito de Columbia y 19 estados tienen leyes que permiten a los inmigrantes indocumentados obtener una licencia de conducir; de ellos, solo Maryland y Virginia están en el sur, dijo **Jean Hernández**, coordinadora del programa de El Centro de Acceso para Latinos de Alabama/The HUB Wellness Clinic de AIDS Alabama. Sin una identificación estatal o una tarjeta de seguridad social, los inmigrantes indocumentados a menudo no pueden acceder a la atención médica o los servicios sociales, lo que conduce a disparidades en la salud y aislamiento social.

“Merecemos ser vistas, escuchadas, liderar y tener un asiento, no en una mesa, sino en todas las mesas, porque la representación es importante para alcanzar la igualdad”, dijo Hernández, una “orgullosa latina y boricua”.

Miguel García, director de defensa de derechos de la Southern AIDS Coalition, contó cómo lo discriminaron racialmente y lo detuvieron en virtud de la ley federal. La patrulla fronteriza es de jurisdicción federal, pero la SB-4 es una ley estatal que faculta a la policía de Texas a arrestar a cualquiera que cruce ilegalmente la frontera con México. Seis vehículos de la policía estatal de Texas rodearon el coche de García durante su viaje de 56 millas para finalizar el papeleo para los servicios de Ryan White. Un oficial le dijo a García, ciudadano estadounidense, que tenía suerte de estar cumpliendo con la ley.


Miguel Garcia

“Imagínense lo que está pasando con nuestros hermanos y hermanas indocumentados”, dijo.

Arely Westley es una defensora de larga trayectoria de los inmigrantes, la gente Latine y las comunidades LGBTQ+. Originaria de San Pedro Sula, Honduras, trabaja con organizaciones en Nueva Orleans y en todo el país para apoyar a los jóvenes LGBTQ+, detener el abuso en los centros de detención de ICE y ampliar el acceso de los migrantes a los servicios de apoyo. Es miembro de la Southeast Dignity Not Detention Coalition, miembro de la junta asesora comunitaria de Tulane Total Health Clinic y recientemente se unió a la junta directiva de Asheboro Latinxs Services y Alianza Trans Latinxs. A principios de este año, recibió el Premio de Derechos Humanos Robert F. Kennedy.


Arely Westly

“Cuando recibí por primera vez el Premio de Derechos Humanos Robert F. Kennedy, dejé en claro que este premio no solo me pertenece a mí, sino a todas las comunidades interseccionales que represento como mujer trans nacida en Honduras que creció en Luisiana”, dijo. “No solo represento a mi comunidad trans latina, también represento a la comunidad latina en todo el país y a toda la comunidad migrante”.

Agregó: “Necesitamos empezar a trabajar juntos de verdad, porque es bueno que nos veamos cada año en esta conferencia, pero cuando regresamos a nuestras ciudades, no sabemos [de alguien]. Necesitamos mantenernos conectados y realmente ser solidarios entre nosotros para poder construir poder. Podemos construir poder juntos”.

Aubri Escalera es cofundadora de Trans Power in Diversity, con sede en Atlanta, y enlace LGBTQ+ de la representante estatal del Distrito 58 de Georgia, Park Cannon.

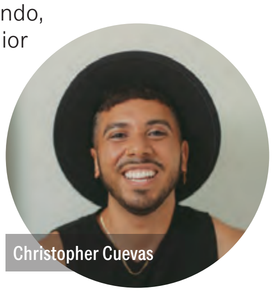
“Como inmigrante trans latina, estoy aquí para defender, empoderar y construir poder colectivo”, dijo. “El poder sureño es poder trans. A menudo, tenemos las herramientas para prosperar, pero carecemos de las credenciales para trabajar. El lenguaje inclusivo es importante, especialmente para nuestra comunidad de inmigrantes mayores de 50 años que viven con VIH. Al unir los esfuerzos legislativos con las organizaciones de base y los centros de salud, podemos crear un futuro donde la comunidad se sienta valorada, protegida y libre”.

Gabriella Rodríguez, directora ejecutiva de QLatinx, señaló las amenazas que plantean las leyes estatales propuestas en todo Estados Unidos.

“Se han presentado más de 530 proyectos de ley perjudiciales contra la comunidad LGBTQ en todo el país, y 251 de ellos están dirigidos contra nosotros aquí en el sur”, afirmó. “No son solo números. Representan una amenaza real para nuestra seguridad, nuestra salud mental, nuestra salud emocional y física, y nuestra propia existencia, pero también he visto la fortaleza ante la adversidad, especialmente después de tragedias como Pulse [el tiroteo fatal en el club nocturno de Orlando]”.

> **“No basta con tener personas que hablen español, también deben entender el lenguaje de la prevención del VIH y ser capaces de comunicar ese mensaje de manera efectiva a nuestra comunidad”.**

Christopher Cuevas, un latino indígena no binario que nació y creció en el sur profundo, es gerente senior de programas en AIDS United.


Christopher Cuevas

“Se estima que en los próximos 30 años los latinos representaremos casi el 30% de la población total de Estados Unidos, lo que nos convierte en el grupo minoritario étnico o racial más grande del país”, dijeron. “También representamos casi el 45% de quienes no tienen seguro médico.

Continuaron: “Si todos los estados de la nación expandieran Medicaid, el porcentaje de latinos sin seguro disminuiría en más del 16%. Debemos hacer todo lo que esté a nuestro alcance para garantizar que cada persona en esta nación pueda pagar una atención médica de calidad y reconfortante”.


Andres Acosta Ardila

“Hay tres cosas que debemos tener en cuenta para mejorar la equidad en materia de salud y la prevención del VIH en las comunidades latinas del sur”, dijo **Andrés Acosta Ardila**, director de relaciones comunitarias de Pineapple Health Care en Orlando. “La primera es la necesidad de representación y justicia lingüística. Sabemos que cuando las organizaciones que prestan servicios a nuestras comunidades tienen personas en todos los niveles de la organización que se parecen a nosotros y hablan nuestro idioma, se obtienen mejores resultados en materia de salud.

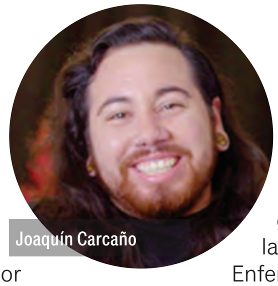
“Pero también debemos tener en cuenta que las personas [que hablan español] necesitan apoyo con el lenguaje médico”, dijo Acosta Ardila. “No basta con tener personas que hablen español, también deben comprender el lenguaje de la prevención del VIH y ser capaces de comunicar ese mensaje de manera eficaz a nuestra comunidad. Eso significa que las organizaciones deben estar dispuestas a invertir tanto en la capacitación como en pagarles adecuadamente a esas personas para que puedan realizar este trabajo.

El segundo es crear una red de apoyo que vaya más allá de los servicios para el VIH. Estoy agradecida de trabajar para Pineapple Healthcare, que es una organización 340B, y puede utilizar esos recursos no sólo para garantizar que las personas tengan acceso a seguros y medicamentos, sino también a servicios de transporte, salud mental y referencias de vivienda para el manejo de casos. No solo eso, sino que patrocinamos fiscalmente organizaciones como Abrigado Corazones, que recolecta ropa, productos de higiene y algunos dispositivos y artículos de movilidad para niños y los distribuye a la comunidad, especialmente a la comunidad inmigrante... Nos asociamos y hemos patrocinado a Aguilar Salud, que se encarga de vincular a las personas latinas con la atención médica, y ha aumentado nuestra capacidad de utilizar servicios de telesalud para vincular a las personas latinas en áreas rurales con la atención médica. Estas redes de apoyo son cruciales para garantizar que nuestra comunidad esté vinculada y se mantenga en atención médica.

“No es suficiente brindar servicios relacionados con el VIH. Tenemos que estar dispuestos a colaborar entre nosotros para formar redes de apoyo.

“Por último, las organizaciones no deben tener miedo de tomar una postura. Somos conscientes de nuestro estatus 501(c)(3) [sin fines de lucro], pero eso no es una excusa para no defender lo que es correcto. Nuestro director ejecutivo, Ethan Suárez, habló abiertamente sobre la necesidad de brindar servicios de atención médica para nuestra comunidad indocumentada y, frente a la prohibición de la atención médica para las personas trans, tomamos todas las medidas posibles para garantizar que nuestra familia trans pudiera acceder a la atención sin sufrir interrupciones en los servicios. Es fundamental comprender que nuestras organizaciones representan la esperanza y un salvavidas para muchas personas, y no podemos permanecer en silencio mientras nuestras comunidades Latinx y LGBTQ están bajo ataque, especialmente cuando esos ataques afectan su atención médica. Todos tenemos que tomar una postura y defender lo que es correcto”.

“Soy una persona que consumió drogas y estoy en proceso de recuperación, y ocupo el cargo de directora de relaciones comunitarias en mi organización. Esto es importante porque a menudo hablamos de las personas que consumen drogas como una población prioritaria, pero no tomamos las medidas necesarias para contratarlas y, al hacerlo, estamos haciendo un deservicio a nuestra comunidad”.


Joaquín Carcaño

Joaquín Carcaño, un reciente graduado de la Escuela de Enfermería de la Universidad de Carolina del Norte en Chapel Hill, es un hombre trans mexicoamericano gay que dirige la política de salud del Sur en la Comisión Latina sobre el SIDA.

“Las tasas más altas de nuevas transmisiones de VIH en Florida Central se dan entre la comunidad Latinx, y sabemos que la condición concurrente más frecuente en Florida Central para las personas que viven con VIH es el consumo de sustancias”, dijo. “La reducción de daños es un salvavidas para los más marginados y estigmatizados en nuestra comunidad, y los principios detrás de la reducción de daños deben aplicarse a todos nuestros esfuerzos de divulgación y prevención. La clave es entender que tenemos que llegar a las personas donde están. No es suficiente simplemente ofrecer métodos de prevención si no consideramos cuidadosamente las necesidades de las personas que consumen drogas. En la comunidad latina, vemos que el estigma se agrava por estar en la intersección de las identidades latinas, el estado serológico y el consumo de drogas.

“He visto todo eso y he experimentado todos esos estigmas yo mismo, y ese estigma mantiene a las personas fuera de la atención”, continuó. “Cuanto más nos centramos en los esfuerzos de reducción de daños que desestigmatizan el uso de drogas, cuanto más seguras pueden sentirse las personas que están luchando para acceder a la atención. También existe la necesidad de que las comunidades latinas, especialmente aquellos de nosotros que nos identificamos como personas que consumen drogas o personas en recuperación, nos unamos a los consejos de planificación... Quiero señalar que soy una persona que consumió drogas, y estoy en recuperación, y tengo el papel de director de relaciones comunitarias en mi organización. Esto es importante porque a menudo hablamos de las personas que consumen drogas como una población prioritaria, pero no tomamos los pasos necesarios para contratarlas, y al hacer esto, estamos haciendo un deservicio a nuestra comunidad.

"Los medios de comunicación tienen esta narrativa que a menudo es errónea o no muestra el panorama completo", continuó. "Pensamos en la atención a las personas trans como, aquí hay una cirugía, aquí hay una inyección. No hablamos del impacto que eso tiene en una persona, en su cuerpo y en su vida, y eso es lo que realmente está en la profundidad de este trabajo, en la profundidad de nuestro acceso a la atención. Crecí sin saber lo que estaba reprimiendo, sin saber lo que había escondido, y desbloquear eso y saber lo que podría existir para mí, a qué posibilidades podría acceder, fue innovador para mí. Y creo que una parte de la atención a las personas trans es decir: Tengo toda una vida más por vivir. Tengo una plenitud a la que aún no he accedido.

"Las restricciones a la atención anti-trans [están] realmente hiperconcentradas en los jóvenes en este momento. Lo que realmente está sucediendo es que dicen, no se les permitirá ser un adulto trans, punto final. No se les permitirá existir como un adulto trans. Los privaremos de eso. Esas consecuencias son enormes para la salud mental y el bienestar de nuestra comunidad, de nuestra juventud. Dicen que están tratando de 'proteger' a nuestra juventud, pero estas son las mismas personas que tuitean pensamientos y oraciones después de un tiroteo en la escuela; eso no es proteger a nuestra juventud.

"El ministro de justicia de Texas ha solicitado a Washington, D.C. y Georgia los registros de pacientes trans de los texanos que han huido de su estado", dijo. "Está encontrando lagunas en los registros de privacidad médica para obtener datos de ex texanos que han huido de su estado y que son trans. Las implicaciones de eso son enormes. Hablamos de autoritarismo y fascismo después de esta elección: está aquí y debemos hacer algo al respecto. Está sucediendo. Es activo. ¿Por qué necesita esta información? ... [En Alabama, donde se aprobó una ley de atención a los jóvenes trans,] se prohibió por delito grave a los proveedores. Si brindaras atención a personas trans, te sancionarían con un delito grave. Están amenazando con revocar las licencias médicas, con poner a los médicos en prisión. Entonces, ¿qué hacen estos médicos? Estamos viendo que los médicos huyen del Sur. ¿Qué significa eso para todo nuestro sistema de salud pública? Los proveedores que brindan atención a personas trans son proveedores de atención primaria y endocrinólogos que también trabajan con pacientes con diabetes. Piensen en las implicaciones para todo nuestro sistema de salud pública. Estamos aumentando nuestra pérdida de proveedores de atención primaria y de proveedores que pueden ocuparse del control de la diabetes. Eso es enorme. Ahí es donde nuestro movimiento de solidaridad intersectorial debe entrar. [Afecta el trabajo de] salud pública, de retención, de nuestra atención sanitaria rural. ¿Quién se verá afectado? Todos nosotros. No se trata solo de la atención a las personas trans".


Will Ramirez

Will Ramirez, moderador del panel, adelantó el próximo Manifiesto de los Estados del Sur, actualización de 2024. "Este informe es la culminación de un trabajo que se ha llevado a cabo durante dos años y que creemos que cuenta una historia completa del VIH en el Sur". Cuando se publique, el informe estará disponible en southernaidscoalition.org.

> **"Cuanto más nos centramos en los esfuerzos de reducción de daños que desestigmatizan el uso de drogas, cuanto más seguras pueden sentirse las personas que están luchando para acceder a la atención".**
>
> — Joaquín Carcaño

POZ ADVOCATE

SCOTT SCHOETTES
@PozAdvocate

Time for the military to march in step on HIV

ISTOCK

We were popping champagne corks in April 2022 after a federal district court ordered the Department of Defense (DOD) to allow service members living with HIV to deploy and commission as officers (see July+Aug 2022). As HIV Project Director at Lambda Legal at the time, I co-led the legal efforts to address the military's discriminatory policies with respect to people living with HIV and was thrilled with this result. It had taken three lawsuits, four years of litigation, dozens of depositions, hundreds of hours of legal work and a trip to the Fourth Circuit Court of Appeals and back, but we had finally secured an injunction forcing the military to stop treating HIV-positive service members as second-class citizens.

Our work, however, was not yet done. For strategic reasons, we had not included a person seeking to enlist among our plaintiffs. And though medical qualification for enlistment is governed by the same standard as medical qualification for commissioning—a policy we did challenge and on which we prevailed—the court did not accept our invitation to rule on the enlistment of people living with HIV.

Nonetheless, with an opinion from the court systematically taking apart the supposed justifications for preventing the deployment and commissioning of service members living with HIV, I had hoped that the rest of the discriminatory aspects of military HIV policy would be dismantled in its wake. A permanent injunction—particularly one against the government—from a federal court is a big deal and sends a strong message that the enjoined party is in the wrong and needs to correct course, so my optimism was not entirely misplaced.

Plus, we now had President [Biden] on our side. We filed the lawsuits against the Trump DOD, but after four years of litigation, the injunction was issued against the now-Biden administration.

We previously had secured statements of support for the military service of people living with HIV from the Biden campaign (as well as the Harris campaign), so it seemed likely the White House would use the injunction and the court's opinion to convince the DOD to stand down on enlistment.

No such luck. The regulations the DOD issued in response to the court's ruling made clear the military was complying with the injunction in the narrowest way possible—still subjecting service members to an onerous deployment waiver process and denying deployments to some locations—and that it would not change the enlistment policy at all. Incredibly frustrating, but not entirely surprising.

In fact, the legal team had already started talking to individuals living with HIV who wanted to join or re-join the military. By the time we had resolved the issue of attorneys' fees to close out the old cases, we were ready to file a new case on behalf of three individuals who wanted to join the military.

The DOD cannot have been surprised by the new lawsuit. We made clear in briefing the previous cases that we thought the enlistment ban was illegal—in fact, unconstitutional—for the same reasons the deployment and commissioning bars were illegal. And the court, in declining to rule on the enlistment question in those cases, all but invited us to bring a new lawsuit with a plaintiff who wanted to enlist to obtain a ruling on that issue.

The DOD's first move was to delay. After we filed the lawsuit, the Secretary of Defense tasked an ad hoc working group with reviewing the enlistment bar, and the Department of Justice (DOJ), as the DOD lawyers, convinced the court to delay proceedings pending the outcome of this review. Unsurprisingly, the DOD made no changes to the enlistment policy based on the recommendations of this working group. The DOD never shared the results of the review, even though the judge specifically asked to see the report, which makes one wonder what the working group in fact recommended.

If the working group recommended allowing people with well-managed HIV to enlist, that recommendation never saw the light of day. Not only did the DOD argue that the additional healthcare costs associated for people living with HIV justified the enlistment bar, they also insisted on *re*-litigating all of the purported justifications for the deployment bar that the court had rejected as irrational in the previous cases.

We could have prevented most defendants from reasserting such failed arguments, but the government is not subject to the legal doctrine known as *claim preclusion*. Even though the judge made clear that without new evidence she would rule the exact same way on these issues, the DOD and DOJ plowed right ahead with their plans. Fortunately, we landed on a strategy that allowed us to defeat these stale arguments without engaging them in detail, but it sure was disappointing to see the DOD continue to cling to its outdated ideas about HIV treatment, the "complexity" of monitoring during deployment, and the risks of transmission in a combat zone. Though the DOD had not appealed the court's ruling and had changed its deployment and commissioning policies accordingly, it had not truly accepted the established science on which that ruling was based.

Even more frustrating than the DOD's refusal to accept the science of HIV treatment and transmission was its willingness to claim that the costs of providing healthcare to service members with HIV justifies refusing to enlist them. Under the Equal Protection Clause, costs can sometimes be a legitimate reason for treating one group differently from another, so citing these additional costs was a sound legal strategy.

But just because a legal argument is available does not mean it should be asserted. As one of the agencies tasked with executing the National HIV/AIDS Strategy (NHAS), the DOD is ultimately controlled by the president, and it is represented by attorneys at the DOJ—the same DOJ that would sue *any other* public employer or entity that tried to claim the cost of healthcare for people living with HIV as a legitimate basis for refusing to employ them.

I had hoped that someone within the Biden administration or at the DOJ would realize the distastefulness of incrementally increased healthcare costs as a purported justification for this policy. It is not the fault of people living with HIV that HIV medications are more expensive than most!

The DOD could not come up with solid evidence that healthcare costs for service members with HIV were significantly higher than for other service members or that the defense department relied on healthcare costs as a basis to deny enlistment to any other group, and we were able to defeat this argument. On August 20, the court issued another ruling against the DOD and imposed an injunction forcing the military to accept enlistees with well-managed HIV.

HIV stigma is perpetuated by misinformation and misconceptions of the very kind on which the DOD based its policy for years.

In the meantime, the administration missed a significant opportunity to support people living with HIV and to advance the aims of the National HIV/AIDS Strategy. HIV stigma is perpetuated by misinformation and misconceptions of the very kind on which the DOD based its policy for years. Convincing the military—with the exalted place it holds in the American psyche—to abandon its ill-informed and discriminatory policies *before* being forced by multiple lawsuits would have conveyed important and accurate messages about HIV treatment and transmission.

As we await the DOD's reaction to the latest ruling, we can only hope the new administration does not miss this opportunity to eradicate the barriers that still exist and to finally embrace the full military service of people living with HIV.

AS OF PRESS TIME, an announcement from the Department of Justice was expected soon. For the latest, **GO TO** positivelyaware.com/march-in-step.

SCOTT SCHOETTES is an attorney and advocate who lives openly with HIV. He engages in impact litigation, public policy work and education to protect, enhance, and advance the rights of everyone living with HIV.


COURTESY OF JUSTIN TERRY-SMITH

The echoes of sexual assault

Justin Terry-Smith kept a secret for 20 years. It nearly killed him

BY **MARK S. KING**

When Justin Terry-Smith talks about what happened to him in 2001, his words and demeanor have a certain detachment. It is a story he has repeated many times, to everyone from law enforcement to emergency room workers to the many friends with whom he has confided over the years.

"I'm a compartmentalization person," Justin says. "Feelings and facts are kept separate." He has good reason to deploy that defense mechanism.

Still, Justin isn't coy about telling the truth plainly. He simply calls it "the rape."

"I went on a date with someone, just one time," Justin begins. "It wasn't the best or the worst date I've ever had. But I decided not to go out with him after that."

A year later, Justin saw the man at a nightclub and they agreed to grab a bite to eat together. Later that night, though, in Justin's car, the man pulled a knife on him.

"He pressed the knife to my skin and told me to kiss him," Justin says. The details are uncomfortable to hear, even if Justin's voice is clear and deliberate. "So, I kissed him. He told me to pull down my pants and he raped me in the car. Afterwards, he told me to give him my car keys. I said no. He grabbed the keys from me and exited the car and walked around to the driver's side."

Justin's use of the phrase "exited the car" sounds like something you would say in a police report. Something about the formal nature of it, of Justin's verbal distancing from the event, reveals his protective defenses.

Justin knew that if the man got back in the car and took the wheel, his life would be in further danger. As the man began to open the driver's door, Justin kicked it hard, plowing the door into his attacker and knocking him to the ground. Justin leapt from the car. There was a struggle for the keys. Justin was bitten on the hand. Finally, Justin was able to break free with his keys and run away.

"My clothes were ripped and I was beat up," he explains. "I made it to a bus that was stopped nearby, and the driver said the police station was on his route. He dropped me off there."

Justin was so traumatized from the attack that police officers thought he was on drugs. "They treated me like a second class citizen," Justin says. "Like I was the criminal, not the victim." Eventually, Justin was transported to a hospital where he endured more distrustful glances and a painful rape kit procedure.

Once police had sufficient evidence, like fingerprints from Justin's car and DNA results, Justin wasn't needed for the prosecution of his attacker. That part of his ordeal was over.

Except that Justin was an airman first class in the United States Air Force and living on a base nearby. At the time, the military was under "Don't Ask, Don't Tell," the absurd military directive forcing LGBTQ+ service members to stay closeted, so Justin was unable to tell anyone else in the military about his rape. He was even afraid to tell a counselor for fear of being discharged, thus denying him crisis intervention when he needed it most.

Justin found himself the victim of a violent rape and unable to speak about it. He was 21 years old at the time.

Justin kept his mouth shut. Weeks turned into months. Secrets, though, have a way of festering into something more dangerous.

"I started to get into trouble," Justin admits. He drank too much. He lashed out at co-workers and was constantly late for work. They sent him to anger management classes. It didn't help.

A full two years after the assault, Justin decided to see a military therapist since his enlistment was ending anyway. "It was the first time I told someone," Justin says. "He was really good. He told me I suffered from post traumatic stress disorder (PTSD). I thought that was something only war veterans had."

Sometimes, though, identifying the source of trauma isn't enough to wash away the repercussions. Justin continued drinking heavily and began experimenting with drugs.

"I wanted to feel numb," he acknowledges. "I slept with a lot of guys. I wanted to feel love and I didn't want to feel pain." His days and nights became fraught with dangerously self-destructive behavior.

And then one morning in 2006, Justin woke up drenched in sweat. "I was very sick," he says. Soon, Justin would receive a positive HIV test result.

It was the latest in a chain of crushing events that began late one night, years earlier, during a fateful drive in Justin's car.

Without emotional or clinical support for his untreated trauma, his self-destructive behaviors continued. "The HIV diagnosis was not the wake-up call," he says.

Some of the support he dearly needed came in the form of Philip, a man Justin met who would help him feel worthy of love. "When we got serious, my behavior got better. But I also realized I need to live for myself."

By 2008, Justin had started therapy again and was seeing real results. "I was allowed to speak my mind fully, to really cry about what happened," he says. "I had not cried about the assault since that night. Nothing in my culture as a Black man allows that kind of emotion."

Today, Justin's life is very different. He has been married to Philip for 15 years and they live on a ranch in New Mexico. They have raised two kids.

Justin's reversal of fortune extends to his military service as well. After an internal review more than 20 years after his service, the Veterans Administration extended full disability benefits to Justin due to his PTSD. "It felt as though after all those years of pain and suffering, that someone finally listened to my truth," he says.

Justin spends much of his time speaking out as a gay man living with HIV. He participated in the recent documentary, *Serve with Pride*, about LGBTQ+ veterans, works with several HIV/AIDS organizations and speaks to community groups about HIV.

On World AIDS Day last year, Justin spoke at the VA hospital, volunteering his service to the very military institution that once muzzled his freedom of speech. He sees the irony and has no regrets.

"Today, it's about moving forward," he says. "I don't feel any shame about my HIV status, and the attack does not dictate how I feel about myself. Not anymore."

Trigger warning: This article includes a description of rape and sexual violence. If you or someone you care about has experienced sexual violence, assistance can be found through the National Sexual Assault Hotline at (800) 656-4673.

MARK S. KING is the author of the essay collection, *My Fabulous Disease: Chronicles of a Gay Survivor*.

Extraordinary lives in one *Day*

Photos from around the world tell the story of A Day with HIV

2:00 PM: WILMINGTON, NORTH CAROLINA. Ed Adams: "Sundays are for Stonewall Sports Kickball, where building community is integral to my thriving as a long-term survivor of HIV."

9:11 PM: NEW YORK, NEW YORK. Juan Michael Porter II: "I thought it was too late to participate in A Day with HIV until I remembered, I have a ring light and the magic of ART. Here on the 28th floor of Manhattan Plaza. Having the chance to be weird for folks who passed before their time inspired me."

The first day of fall—the autumnal equinox—is one of only two days out of the year when night and day are of equal length. In some ancient cultures, the equinox not only marked the changing of the seasons, it signified a change in thinking. What better day to fight stigma?

A Day with HIV is POSITIVELY AWARE's annual anti-stigma project. Now in its 15th year, it portrays 24 hours in the lives of people living with—and affected by—HIV with selfies and other photos all taken on the first day of fall, September 22. The pictures are posted on social media with a caption giving the time and location they were taken, accompanied by the hashtag #adaywthhiv.

For long-term survivor T.J. Elston, A Day with HIV is significant for many reasons. September 22 is his birthday and wedding anniversary with his husband, James. "Eighteen years together," he says, "our fifth wedding anniversary is today!"

In Puerto Rico, Jacqueline Sepulveda took a selfie with family members. "Compartiendo con familia y viviendo una vida de ayuda y abogacía para la comunidad VIH positiva," she posted in Spanish. *Sharing with family and living a life of helping and advocating for the HIV community.*

Melvin Wright's picture is a tribute. "Telling the story of my sister, whom I lost to AIDS," he says.

That Sunday was an opportunity for quiet time for Patrick Ingram. "After a tough week I spent my day with HIV exercising radical rest," he says. "It's so important for people of color thriving with HIV and advocating for community to never forget that freedom is a constant struggle."

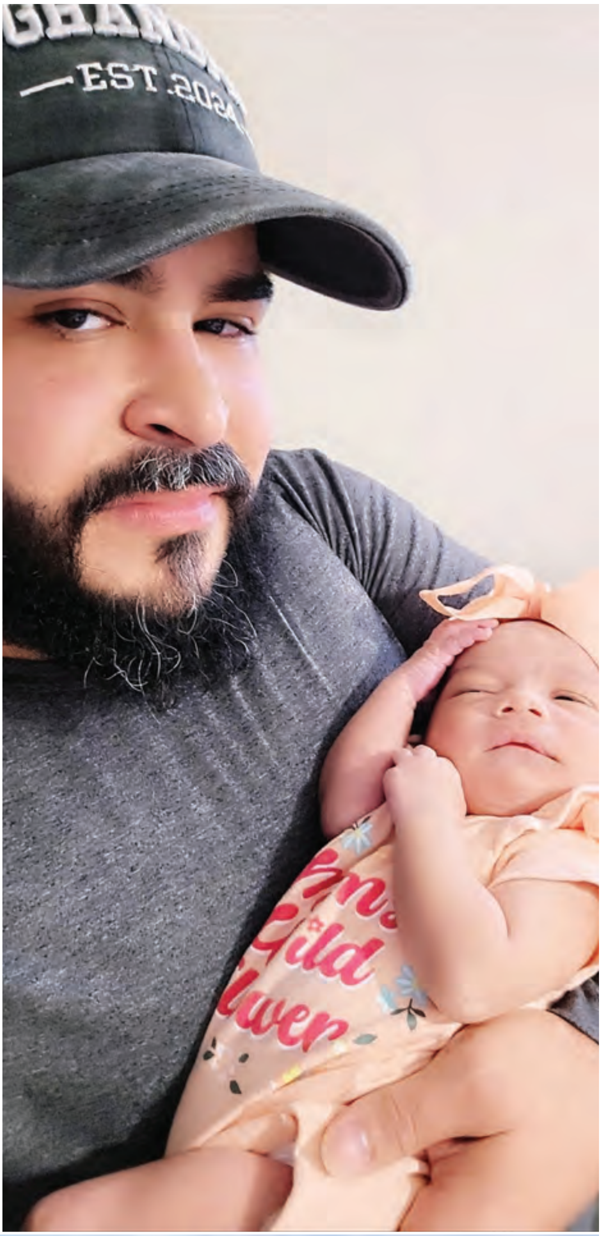
With his photo, Marco Mays acknowledges that not everyone living with HIV might feel comfortable enough to be so visible, especially in the current political climate. "It seems no matter what state you live in, there are things at work to push our HIV community to the shadows to be unseen," he says. "I challenge each and every one of you who feels unseen to start making your silhouette just as powerful as your presence showing up in the light!"

Everyday moments in extraordinary lives is one of the project's taglines, and Paul Edmond's picture is one example. "I'm the fifth person in the world that has been cured of HIV after a stem cell transplant," says Edmonds. "Now, my purpose is to inspire people worldwide that a cure for HIV is possible and to help to stop HIV stigma. The HIV community has been my community for the past 36 years and that will never change."

Another everyday moment was shared by Jyoti Dhawale in Bangalore, India. "It is festival season in India and around this month, there is a tradition of deep-cleaning the house," she says. "So here is me, doing the chores, with a coffee break in between."

—**RICK GUASCO**

THE FOLLOWING SEVEN PAGES feature pictures from A Day with HIV, displayed according to the time of day they were taken. Some captions have been edited for brevity and clarity. An online gallery is on display at adaywithhiv.com. **FOLLOW** @adaywithhiv on Instagram, X (formerly Twitter) and Bluesky. A Day with HIV will return on the first day of fall, Monday, September 22, 2025.



<< 8:00 AM:
TYSON'S CORNER, VIRGINIA
Daniel J Pino: "Eleven years ago, when I was first diagnosed with advanced HIV, the doctors told me owning a cat might not be possible. Fast forward to today, and this bratty diva brings me so much joy and smiles every single day."

<< 9:48 AM:
SPOKANE, WASHINGTON
Princess Dallas Lyle: "Preparing to be a deacon during worship at the historic Westminster UCC in Spokane. Sending prayers of gratitude to God for all of the blessings in my life."

< 9:58 AM:
BAYAMON, PUERTO RICO
Isareal Samalot Doval: "¿Sabías que mantener una carga viral indetectable es una de las mejores cosas que puedes hacer para mantenerte saludable si tienes VIH? Recuerda que luego de un diagnóstico positivo al VIH, hay una vida. La enfermedad puede ser un obstáculo para el cuerpo, pero no para la voluntad y capacidad de levantarte y ser la mejor version de ti. Hoy junto a mi regalo del 2024 (mi nieta), agradezco la oportunidad de servir a la comunidad con un diagnóstico positivo al VIH o SIDA.

"Did you know that maintaining an undetectable viral load is one of the best things you can do to stay healthy if you have HIV? Remember that after a positive HIV diagnosis, there is life. The disease can be an obstacle for the body, but not for the will and ability to get up and be the best version of yourself. Today, together with my gift of 2024 (my granddaughter), I am grateful for the opportunity to serve the community with a positive HIV or AIDS diagnosis."

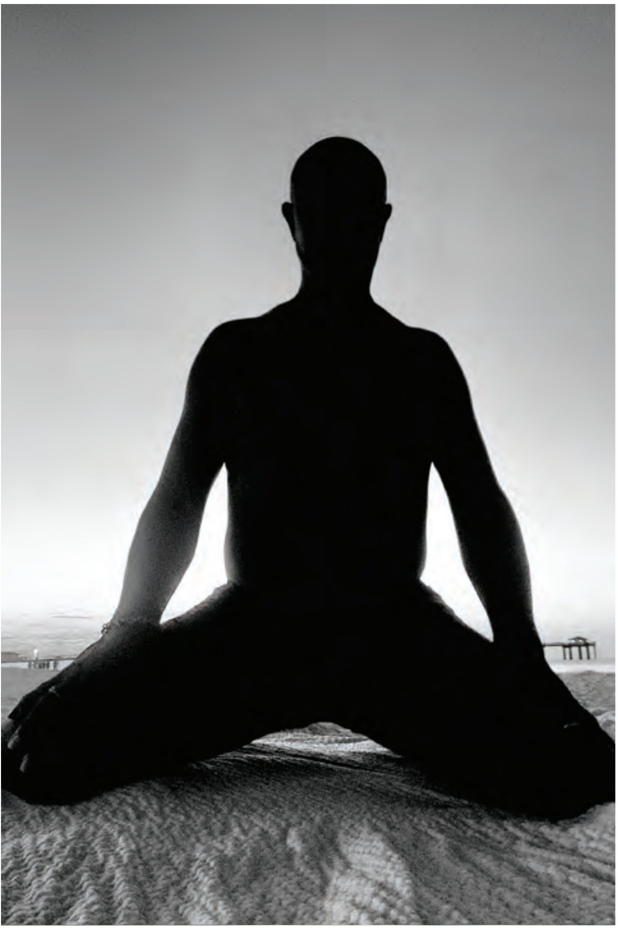
< 10:15 AM:
ASHLAND, VIRGINIA
Melissa Dennis: "Continuing traditions."

10:15 AM: HOUSTON, TEXAS >
Bob Bowers and Nita Costello: "We wear our bracelets in memory of the friends and family we've lost to HIV/AIDS (and to comorbidities, depression, suicide and overdoses) and for the hope that each new day brings."

11:06 AM: LONDON, ENGLAND; UNITED KINGDOM >
Emma Cole: "Enjoying Sunday morning coffee with my friend, neighbour and fellow long-term survivor, Martin."

11:15 AM: NEW YORK, NEW YORK >
David Phillips: "Grumpy Santa recording auditions for holiday ads; 42 years, 18 days of being a ho-ho-host for the virus."

11:30 AM: LOS ANGELES, CALIFORNIA >
Jack R. Miller: "Sunday morning on the Los Angeles Metro system. I'm on my way to work. I love the beautiful artwork in the Los Angeles Metro stations and it inspires me to continue living my life to the fullest until God calls me home!"



<< 12:21 PM: MONTGOMERY, ALABAMA
Marco Mays: "It seems no matter what state you live in, there are things at work to push our HIV community to the shadows to be unseen. I challenge each and every one of you who feels unseen to start making your silhouette just as powerful as your presence showing up in the light! Maybe even more!"

< 12:45 PM: LEHIGH ACRES, FLORIDA
Cathy Robinson Pickett: "I'm spending a relaxing Sunday at home, counting my blessings of turning 59 this week and living 40 years with HIV!"

<< 12:50 PM: FORT WALTON, FLORIDA
Bee Velásquez: "Conference mode. Sometimes you need to lie down, take a break and a breather. Self-care is very important. Remember, you are important, and you matter!"

12:50 PM: NEAR BRYSON CITY, NORTH CAROLINA >
Harold Scott: “Riding the Nantahala Gorge Train Excursion from Bryson City. I chose this pic as it shows me enjoying the day and at peace in the mountains. One day of 35 years as a survivor with HIV.”

12:55 PM: CHARLOTTESVILLE, VIRGINIA >>
Shawn Decker: “Diagnosed with HIV at age 11 means that most of my days have been days with HIV. At 49, I’m thankful for the advancements in the treatment of HIV that gave me the opportunity to far outlive my initial prognosis in 1987. I wear my AIDS Memorial t-shirt as a reminder to stay connected with my spirit, to let the bright lights of those we have lost—and their loved ones—know that they will be forever remembered.”

1:39 PM: COLUMBIA, SOUTH CAROLINA >
David Maurice Griffin: “As a person living with HIV, I strive to provide HIV awareness to my minority and LGBTQIA+ community on topics of prevention and treatment, U=U, and an end to stigma and criminalization laws plaguing the South. As a force for change, I want to create change in my community.”

2:49 PM: DESERT HOT SPRINGS, CALIFORNIA >>
Paul Edmonds: “I tested positive for HIV and received an AIDS diagnosis in 1988. In 2018, I was diagnosed with amyloid leukemia and needed a stem cell transplant. On February 6, 2019, I received the transplant. My donor had a CCR5-delta 32 mutation which prevents HIV from attaching to your cells. Now, my HIV and leukemia are in remission. I’m the fifth person in the world that has been cured of HIV after a stem cell transplant. Now, my purpose is to inspire people worldwide that a cure for HIV is possible and to help to stop HIV stigma. The HIV community has been my community for the past 36 years and that will never change.”

<< 2:52 PM:
SAN GERMAN, PUERTO RICO
Jacqueline Sepulveda: "Compartiendo con familia y viviendo una vida de ayuda y abogacía para la comunidad VIH positiva."

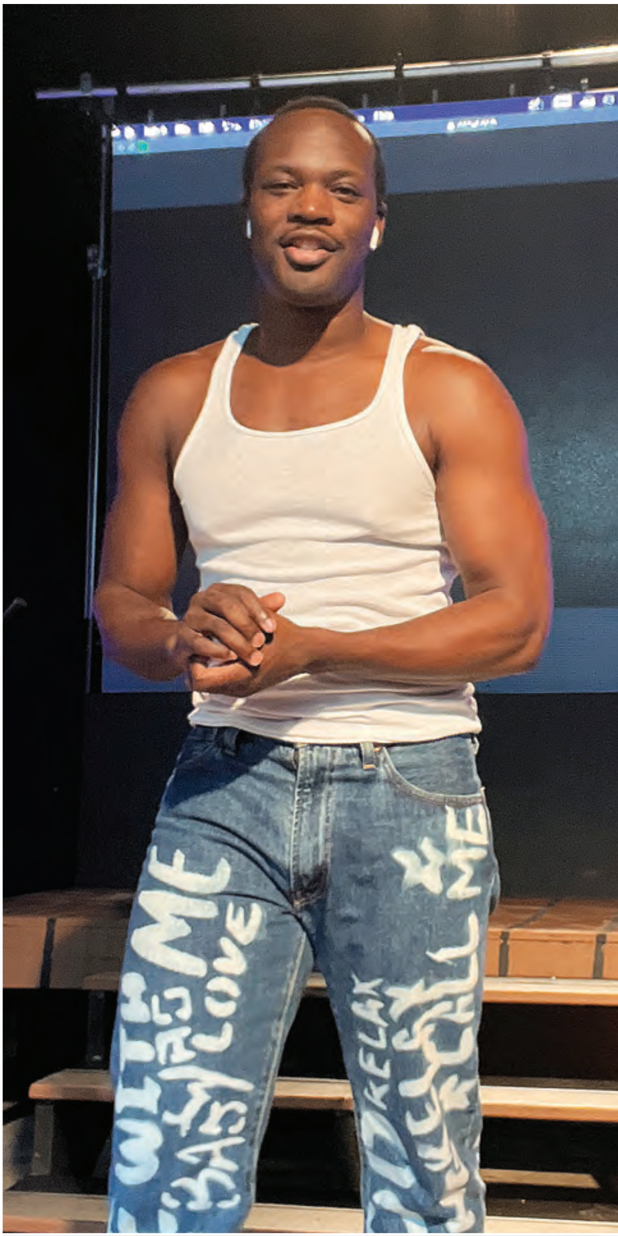
"Sharing with family and living a life of helping and advocating for the HIV community."

<< 3:00 PM:
SAN ANTONIO, TEXAS
Zeke Garcia Murton: "H.I.V.T.E.A.M.—Heroic. Inspirational. Voices. Together. Everyone. Achieves. More. On my way to work at my gold standard AIDS area service provider/agency, the San Antonio AIDS Foundation (SAAF). I invoke my inner hero by speaking out loud to my self-inspiration and affirmation mantra, 'It's a beautiful day to save lives!' Thirty-two years HIV-positive and counting!"

< 3:40 PM:
SEATTLE, WASHINGTON
TJ Elston: "Another year with this man-James, on my left. Eighteen years together, our fifth wedding anniversary is today! Fifty-fifth Belly Button Birthday today! Twenty-five years living with HIV. Long-time participant and past cover boy."

4:09 PM: POMPANO BEACH, FLORIDA >
Melvin Wright: “Telling the story of my sister whom I lost to AIDS.”

6:37 PM: ATLANTA, GEORGIA >>
Michael Ward: “When I was diagnosed, I didn’t know how long I’d be able to continue working as a performing artist. As a storyteller, I use art as advocacy to combat HIV stigma. I’m living my dreams while taking care of my mental and physical health. I took a quick snap before stepping onstage to play Dr. Martin Luther King, Jr., in *For the Love of Mahalia*.”



4:30 PM: SAN JUAN, PUERTO RICO >
Ronaldo Andrés: “Trabajando en el Departamento de Salud de Puerto Rico, buscamos hacer accesibles las pruebas, prevención y enlace a tratamiento, mientras educamos y eliminamos el estigma que nos afecta.

“No importa tu resultado, hay opciones para cuidar tu salud como comenzar en PrEP o TAR (tratamiento antirretroviral para VIH), donde podemos alcanzar una carga viral indetectable y no transmitir a nuestras parejas sexuales.”

“Working in the Puerto Rico Department of Health, we seek to make testing, prevention and linkage to treatment accessible, while educating on and eliminating the stigma that affects us.

“No matter your result, there are options to take care of your health such as starting PrEP or ART (antiretroviral treatment for HIV), where we can reach an undetectable viral load and not transmit to our sexual partners.”

6:43 PM: SAINT PAUL, MINNESOTA >
Patrick Ingram: “After a tough week I spent my day with HIV exercising radical rest. It’s so important for people of color thriving with HIV and advocating for community to never forget that freedom is a constant struggle.”

6:45 PM: KANSAS CITY, MISSOURI >>
Anjie: “Emerging and being Positively Rare.”

<< 7:20 PM: ATLANTA, GEORGIA
@DasJustEddie: "It's Sunday Funday and I'm turnt up with my peeps! I took this pic to share a lil' joy with the world! In all the chaos of our lives, it's important to remember the good."

< 7:22 PM: BANGALORE, INDIA
Jyoti Dhawale: "I decided to take a picture that normalises living with HIV. It is festival season in India and around this month, there is a tradition of deep-cleaning the house, so deep-rooted in the belief in our culture that God visits only clean, clutter-free and beautifully decorated homes, which in turn attracts blessing and prosperity. So here is me, doing the chores (since morning), with a coffee break in between."

< 7:35 PM: DOUGLASVILLE, GEORGIA
Ken Robert Williams: "In my pursuit of growing the biggest, most fluffiest beard I can manage, I stumbled across a few parallels. Like having HIV, growing a beard comes with a daily consideration to care for and protect jealously this undeniable force of your identity, without ever allowing that force to identify you.

"Both journeys have required that I surrender myself. Not to 'give up' but to radically 'give in.' To radically embrace my faith, power and convictions especially when I can't always be in control.

"Like having HIV, growing a beard has become one of my greatest teachers. So, today I get in the picture to celebrate all of our other daily considerations, and how it's been a million dollar audacity to grow a beard."

<< 8:00 PM: BROOKLYN, NEW YORK
Damon L. Jacobs: "Just ran into Billy Porter during the Eagle NYC Sunday Beer Blast!"

< 11:35 PM: SACRAMENTO, CALIFORNIA
Arturo Jackson III: "I'm a long-term, 43-year+ poz survivor, taking all my meds to stay alive another day!"

BEING BRIDGETTE

Bridgette Picou

Watch how you talk to me—I talk back

Internal dialogue can be a good thing. It can motivate you to keep going, encourage you to pivot without giving up when things are not going right and can allow for giving yourself a silent high-five and word of affirmation. I have two voices in my head. The one that gives me the "You betta go with your bad self, Bridgette" encouragement and the one that admonishes me when I do something I think is dumb. That one usually starts with "Look here, silly broad—get it together." We are always the first to hear the words we say as they process through thought to the language function in our brain. That process is so fast! A thought can solidify before we have even fully thought it through.

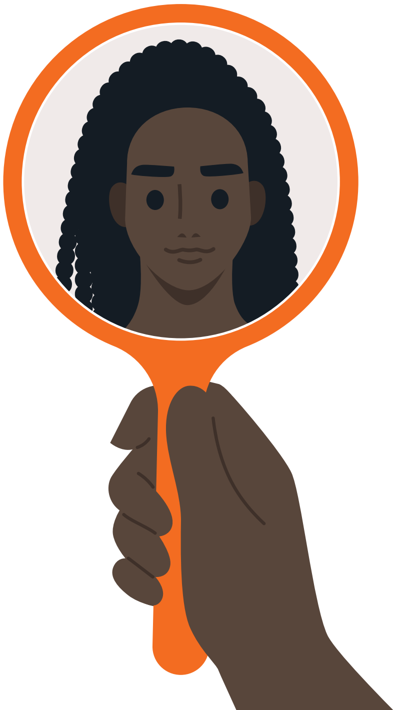
Words have power, but they don't have to control you.

I have learned over time to be careful how I talk to myself and how I say the things I say to others. Language is a choice.

Similar, but subtly different, is the process of listening, or the external dialogue we engage in. Whether it is reciprocal conversation or just listening, I think we often hear with our emotions first, then the words process into understanding and thought. Think of it like this: If someone is talking to you and they say, "I love...," you're already feeling the warm and fuzzies before you process the rest of their words "...cinnamon red-hot candy." It's a bit of a letdown (unless you love them too), when you realize it wasn't "I love you," right? Emotion before meaning, you get me?

I've learned to be careful of how I listen to what people say to me and how I take it in. Language is a behavior.

It may well be that I think too much, but I spend a lot of time considering language and words. I love them both. I love the combinations of tone, diction and cadence that can make the same sentence sound (and feel) distinctly different coming from two different people. I think about the range of emotions words can put us through. From joy to grief, anger to laughter or pride and shame, words have power. I genuinely love the way some words taste on the tongue and feel in my brain. Governance of my own use of language can control the kind of morning I have, or how my day ties up. The consideration of how others use language and their control (or lack thereof) of the words they choose can determine how much emotional weight I take from them. Having said that, I have a series of words for you to consider. Before I give them to you, make a conscious effort to see how you hear them, how you process them and how they make you feel.



Stigma. You deserve what you got. *AIDS.* How can you expect anyone to love you like that? *Shame.* It's your own fault. I'm HIV. *Sick.* Maybe you should only date your kind. *Dirty.* You should have said that before I went out with you. *Isolated.*

Words have power, but they don't have to control you. Some of those words caused me pain, or anger or to flinch and shrink at one time or another. It wasn't all of them, nor was it all at once. But gradually, as I learned to process others' use of language and my way of how much I take in, those words lost their power. For example, "You deserve what you got." That is correct. I *deserve* the growth, the wisdom I've gained. I deserve the love of a community of people living with the same life process that I am going through, my acquisition of HIV. I would not be the same woman without getting what I got. See what I did there? While I have you here, may I gently, but firmly, suggest you take the words "I'm HIV" out of your lexicon? It's an unconscious form of self-stigma. By phrasing it that way, you give the virus power over your identity. We are not HIV; it lives with us.

Stigma holds the power you give it and the emotional weight you grant it. Take in what you need. Leave the rest. Choices and behaviors. They are after all, nothing but words.

Be well. You matter.

BRIDGETTE PICOU, LVN, ACLPN, is a licensed vocational and certified AIDS Care Nurse in Palm Springs, California. She works for The Well Project-HIV and Women as their stakeholder liaison. Bridgette is a director at large for ANAC (the Association of Nurses in AIDS Care), and a sitting member of the board of directors for HIV & Aging Research Project-Palm Springs (HARP-PS). Bridgette's goal is to remind people that there are lives being lived behind a three- or four-letter acronym.

PICOU: CHAD SAIN · ISTOCK