PA POSITIVELY AWARE

HIV TREATMENT, PREVENTION, AND SUPPORT FROM TPAN
SEPTEMBER+OCTOBER 2017

UNDETECTABLE = UNTRANSMITTABLE

GROUNDBREAKING PREVENTION EFFORT

WHAT YOU SHOULD KNOW ABOUT LIVING WELL WITH HIV

BACK TO BASICS

Edd, Nestor, Ceasar, AND **Lenworth** SHARE A COMMON TURNING POINT IN THEIR LIVES

GOODBYE TO 'RISK'

WATCH YOUR WORDS

INTERNATIONAL AIDS CONFERENCE

REPORT FROM PARIS

NEXT STEPS

FIND A PROVIDER, KNOW YOUR RIGHTS, AND MORE

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That's why starting and staying on HIV-1 treatment is so important.

WHAT IS DESCOVY®?

DESCOVY is a prescription medicine that is used together with other HIV-1 medicines to treat HIV-1 in people 12 years and older. DESCOVY is not for use to help reduce the risk of getting HIV-1 infection. DESCOVY combines 2 medicines into 1 pill taken once a day. Because DESCOVY by itself is not a complete treatment for HIV-1, it must be used together with other HIV-1 medicines.

DESCOVY does not cure HIV-1 infection or AIDS.

To control HIV-1 infection and decrease HIV-related illnesses, you must keep taking DESCOVY. Ask your healthcare provider if you have questions about how to reduce the risk of passing HIV-1 to others. Always practice safer sex and use condoms to lower the chance of sexual contact with body fluids. Never reuse or share needles or other items that have body fluids on them.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about DESCOVY?

DESCOVY may cause serious side effects:

- **Worsening of hepatitis B (HBV) infection.** DESCOVY is not approved to treat HBV. If you have both HIV-1 and HBV and stop taking DESCOVY, your HBV may suddenly get worse. Do not stop taking DESCOVY without first talking to your healthcare provider, as they will need to monitor your health.

What are the other possible side effects of DESCOVY?

Serious side effects of DESCOVY may also include:

- **Changes in your immune system.** Your immune system may get stronger and begin to fight infections. Tell your healthcare provider if you have any new symptoms after you start taking DESCOVY.
- **Kidney problems, including kidney failure.** Your healthcare provider should do blood and urine tests to check your kidneys. Your healthcare provider may tell you to stop taking DESCOVY if you develop new or worse kidney problems.
- **Too much lactic acid in your blood (lactic acidosis),** which is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat.
- **Severe liver problems,** which in rare cases can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark "tea-colored" urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain.
- **Bone problems,** such as bone pain, softening, or thinning, which may lead to fractures. Your healthcare provider may do tests to check your bones.

The most common side effect of DESCOVY is nausea. Tell your healthcare provider if you have any side effects that bother you or don't go away.

What should I tell my healthcare provider before taking DESCOVY?

- **All your health problems.** Be sure to tell your healthcare provider if you have or have had any kidney, bone, or liver problems, including hepatitis virus infection.
- **All the medicines you take,** including prescription and over-the-counter medicines, vitamins, and herbal supplements. Other medicines may affect how DESCOVY works. Keep a list of all your medicines and show it to your healthcare provider and pharmacist. Ask your healthcare provider if it is safe to take DESCOVY with all of your other medicines.
- **If you are pregnant** or plan to become pregnant. It is not known if DESCOVY can harm your unborn baby. Tell your healthcare provider if you become pregnant while taking DESCOVY.
- **If you are breastfeeding** (nursing) or plan to breastfeed. Do not breastfeed. HIV-1 can be passed to the baby in breast milk.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Please see Important Facts about DESCOVY, including important warnings, on the following page.

Ask your healthcare provider if an HIV-1 treatment that contains DESCOVY® is right for you.

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(des-KOH-vee)

IMPORTANT FACTS

This is only a brief summary of important information about DESCOVY® and does not replace talking to your healthcare provider about your condition and your treatment.

MOST IMPORTANT INFORMATION ABOUT DESCOVY

DESCOVY may cause serious side effects, including:

- **Worsening of hepatitis B (HBV) infection.** DESCOVY is not approved to treat HBV. If you have both HIV-1 and HBV, your HBV may suddenly get worse if you stop taking DESCOVY. Do not stop taking DESCOVY without first talking to your healthcare provider, as they will need to check your health regularly for several months.

ABOUT DESCOVY

- DESCOVY is a prescription medicine that is used together with other HIV-1 medicines to treat HIV-1 in people 12 years of age and older. DESCOVY is **not** for use to help reduce the risk of getting HIV-1 infection.
- **DESCOVY does not cure HIV-1 or AIDS**. Ask your healthcare provider about how to prevent passing HIV-1 to others.

BEFORE TAKING DESCOVY

Tell your healthcare provider if you:

- Have or had any kidney, bone, or liver problems, including hepatitis infection.
- Have any other medical condition.
- Are pregnant or plan to become pregnant.
- Are breastfeeding (nursing) or plan to breastfeed. Do not breastfeed if you have HIV-1 because of the risk of passing HIV-1 to your baby.

Tell your healthcare provider about all the medicines you take:

- Keep a list that includes all prescription and over-the-counter medicines, vitamins, and herbal supplements, and show it to your healthcare provider and pharmacist.
- Ask your healthcare provider or pharmacist about medicines that should not be taken with DESCOVY.

HOW TO TAKE DESCOVY

- DESCOVY is a one pill, once a day HIV-1 medicine that is taken with other HIV-1 medicines.
- Take DESCOVY with or without food.

POSSIBLE SIDE EFFECTS OF DESCOVY

DESCOVY can cause serious side effects, including:

- Those in the "Most Important Information About DESCOVY" section.
- Changes in your immune system.
- New or worse kidney problems, including kidney failure.
- Too much lactic acid in your blood (lactic acidosis), which is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat.
- Severe liver problems, which in rare cases can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark "tea-colored" urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain.
- Bone problems.

The most common side effect of DESCOVY is nausea.

These are not all the possible side effects of DESCOVY. Tell your healthcare provider right away if you have any new symptoms while taking DESCOVY.

Your healthcare provider will need to do tests to monitor your health before and during treatment with DESCOVY.

GET MORE INFORMATION

- This is only a brief summary of important information about DESCOVY. Talk to your healthcare provider or pharmacist to learn more.
- Go to DESCOVY.com or call 1-800-GILEAD-5
- If you need help paying for your medicine, visit DESCOVY.com for program information.

GILEAD

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FRONT COVER BACKSTORY

TURNING POINT

DISCOVERING THAT YOU'RE HIV-POSITIVE can be a turning point in anyone's life. The four men photographed by Los Angeles photographer **Louis Carr** for the cover of this issue recall receiving their HIV diagnosis and how it changed their outlook on life.

ON THE COVER AND ABOVE, FROM LEFT TO RIGHT: EDD COCKRELL, NESTOR JOSUE ROGEL, CEASAR CORONA, AND LENWORTH POYSER, PHOTOGRAPHED BY LOUIS CARR AT THE VENICE PRIDE LIFEGUARD TOWER, VENICE BEACH, CALIFORNIA.

Ceasar Corona, 40, learned he was HIV-positive in March 2008, at the depth of his crystal meth addiction.

"Testing positive gave me the justification to keep using drugs and alcohol," Cornona says. "I continued to use recklessly and engaged in risky behaviors that led to my getting arrested multiple times and getting sentenced to a year in county jail in 2010. It was in jail where I learned that my HIV had worsened, and that I also had syphilis and was hepatitis C reactive. The medical team along with a transitional case manager helped me get connected to care.

"The multiple diagnoses and jail were a big wake up call. It was in jail that I decided that I cannot do this alone. I listened to the advice I was given, and educated myself. Upon release, I sought help and was able to get into an inpatient facility that helped me understand my addiction. It helped me rediscover my passion for life and healthy living," says Corona, who is now a case manager at an HIV treatment center. "Today, I have seven years living clean and sober, have an active lifestyle in fitness and health, and provide case management to others who are currently dealing with addiction and/or HIV."

The day after a sex partner told **Edd Cockrell** that he'd tested HIV-positive, the 27-year-old went to the Saint Louis (Missouri) LGBT Center, where he volunteered, and took a rapid HIV test.

"It was the longest 20 minutes of my life," says Cockrell.

"Growing up in the Midwest I didn't know much about HIV," he admits. "My first reaction was that I needed to prepare to die. But I quickly found out this was not at all true. Several friends came out to me as HIV-positive, and they were long-term survivors."

Cockrell learned he was HIV-positive in September 2011, and went on treatment in December. By March the following year, he became undetectable and has remained so ever since.

"One thing I have done differently since testing positive is that I make sure I have a conversation with all of my sexual partners about my HIV status and STI status, and theirs," says Cockrell, an analyst for a health insurance software company. "I can't take for granted that people read my profile on hook-up apps," he says.

"Many people in the LGBTQ community who are HIV-positive are stigmatized in so many ways. Instead of stigmatizing individuals, I wish we would start an authentic conversation. Instead of using words such as 'clean' to describe someone who doesn't have HIV or an STI, let's ask when did they have their last HIV screening, and what was the result."

At the age of 27, **Nestor Josue Rogel** is a long-term survivor. He was born with HIV.

"Having been born HIV-positive, I've been on treatment for as long as I can remember. However, it wasn't until I was 12 that I was told I was taking antiretrovirals.

"Having to take a pill every day can blur in my mind," admits the HIV outreach specialist. "Taking my medication every day can be difficult because I don't remember if I took it that day, or if I'm just remembering from the day before.

"Being born with HIV, I have known that it is a part of me. But I don't think I'm different; I am human, like everybody else."

Lenworth Poyser had a feeling, so he wasn't surprised when he tested HIV-positive in September 2011. "I'm still not sure what that feeling was," he says. "I was well informed about HIV, so I knew where to get tested and knew not to flip out—even if my imagination got carried away for a couple days. I asked a close friend to go with me."

Confirming his feeling has made Poyser more decisive about his life. "I tend to work out and exercise more than I did before my diagnosis," Poyser says. "I decided to take my fitness goals a little more seriously, and that makes me feel more confident about myself and what I can achieve. I always wanted to be a more serious musician, and becoming HIV-positive made me want to chase after my goals harder than before. Hopefully, in a few months, I'll be releasing my first independent country music album."

For now, Poyser is a health educator for the B3 Project, an intervention and support program for HIV-positive young gay men of color ages 12–24, at Children's Hospital Los Angeles. His job keeps him knowledgeable about new HIV treatments, even as he's aware of the challenges of adherence and stigma.

"I'm really excited to see how the [long-acting] antiretroviral injection treatments being studied will work out," he says. "I think taking a pill can be a source of stigma for many people, even among the young men I work with at the B3 Project. I hope that a once-a-month injection will get more people [to be adherent]. Once that happens, new infection rates will hopefully drop.

"The average person still thinks AIDS is inevitable for someone living with HIV," Poyser adds. "Trying to explain to people that I'll be fine can be exhausting. Why don't more people know more about HIV?"

—LOUIS CARR WITH **RICK GUASCO**

POSITIVELY AWARE
JOURNALISM. INTEGRITY. HOPE.

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"U=U frees you from the chains and bondage of being seen as a vector of transmission, and into a human being with needs, wants, and desires just like anyone else."

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A WORLD POSITIVELY AWARE
OF HIV AND RELATED CONDITIONS.

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TPAN was founded in 1987 in Chicago as Test Positive Aware Network, when 17 individuals 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.

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STAGE ACTION U=U ACTIVISTS STORM THE STAGE DURING A PLENARY SESSION AT IAS 2017 IN PARIS.

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Hep C treatment in prison

Good news: The Federal Bureau of Prisons (FBOP) has changed its criterion regarding who can get hep C treatment. It was given to inmates with Stage 4 cirrhosis, but now inmates with HIV and minimal liver damage are eligible to receive hep C treatment. I am grateful for this change. Please pass on the good news.

—**Daniel Brown**
LORETTO, PENNSYLVANIA

A BRIGHT LIGHT IN A DARK PLACE

After being away from this correctional institution for 10 months, I had four issues waiting for me in the mail room, and one more came shortly after. Thank you for keeping them coming! I was diagnosed back in 2013. It's hard to believe that it's been four years already. Anyway, thanks to POSITIVELY AWARE, I am much more knowledgeable about the disease. At least now I can ask informed questions when I go in to see the DOH physician every 90 days. I can tell by the look on their faces that they are somewhat surprised when I ask questions. I never reveal to them my source of "good information." I love it. Keep the info coming, please! Your magazine is a bright light in such a dark place. My numbers are excellent, undetectable viral load, and over 1,000 T-cells. My health care provider just recently switched me from Complera to Odefsey all because I asked about it after reading about the lower risk for liver damage in one of your publications. So hopefully the next time I give blood my numbers will be the same or better. Unfortunately, here in prison those "thriving" with HIV are highly stigmatized. Not just by other inmates but by some staff members as well. I find that I kind of have to hide my issues of POSITIVELY AWARE from prying eyes for fear of being stigmatized and consequently treated as a leper.

—**NAME WITHHELD**
MALONE, FLORIDA

THE REUNION PROJECT

I would like to get more information on your event to be held in Seattle. I have been living with HIV since 1984 and lived six years with zero T-cells until triple therapy was tested and rolled out. I was sent home to pass twice from the hospital in the mid-90's. I am currently fully employed (over 20 years), fully engaged in a separate but full life. I am reminded every waking moment of the battle and challenge of HIV as the scar I live with is blindness.

THE REUNION PROJECT SEATTLE

When I was healthy enough to get back into living after six years of waiting to die, I was faced with learning how to engage with the world as a blind person. The blindness has become a constant factor leading to my strong spirit of independence, but also my sense of social isolation. I spend much time educating the sighted world on the abilities and strengths I bring to most situations. I spend an equal amount of energy letting people know how they can assist without victimizing me.

—**MARK**
SEATTLE

EDITOR'S NOTE: Information was sent to Mark for The Reunion Project Seattle, which took place August 18–20 after this issue went to press. More information is at tpan.com/reunion-project.

ADVOCACY BEHIND BARS

I am a 32-year-old gay male. I am also living with HIV and currently incarcerated in the Idaho State prison system. I am fighting the stigma of HIV in the eyes of those who would have me segregated because they fear the virus inside of me. But I refuse to hide the fact I've had HIV for seven, going on eight years and I am healthier than they are. I am working with medical staff from Corizon Health Service, who provide an HIV education program in prison. Yet, they will not even provide vitamins that I should be taking. Their excuse is, "We sell multivitamins on commissary, and therefore we have made them available to you. There has been no study done that shows that vitamins help HIV patients." Despite the fact the vitamins cost nearly $20 and I am indigent. Even when I was working in the kitchen, I was paid under $15 a month. I am writing for a subscription free to HIV-positive people, for the info I need to continue my advocacy with Corizon and the Idaho Correctional System. Thank you.

—**BRANDON PIERCE**
OROFINO, IDAHO

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EDITOR'S NOTE
JEFF BERRY

@PAeditor

UNITY

I write this just a few days after the monstrous, hideous attack on counter-demonstrators in Charlottesville, and only one day after Trump doubled down on them. During a press conference about "infrastructure," 45 attempted in his remarks to create a false equivalency between those opposing hatred and bigotry who were standing up for everything that's right about this country, and those who promote ugly, hateful views and rhetoric that go against everything this country stands for: inclusion, equality, and diversity.

It was exactly one year ago that I wrote another editor's note in POSITIVELY AWARE and talked about the importance of community following the tragic events that took place at the Pulse nightclub. I, like everyone else, was horrified and saddened by the massacre at the popular gay hotspot in Orlando. But as with other tragedies that had come before, I was somehow able to find a way to honor those we lost, while remaining hopeful that maybe things would change in the future.

It's becoming increasingly difficult for me to remain hopeful; I have to consciously make an effort each and every day *not* to amplify the negative, as it swirls around me in social media and news outlets. Endless video loops of senseless violence and report after report of man's inhumanity to man make you start to believe that it is our essence, and that when you get down to it, all this ugliness is ultimately who and what we are as humans.

I refuse to believe that. But it's hard to resist the temptation to "share" or "like" the negative posts. I often feel like my newsfeed in Facebook has become the high school yearbook that you tried to get everyone to sign combined with the negative stream of consciousness that I've worked all my life to get away from.

I have no idea what will have transpired in the three weeks between the time I write this and when it gets printed and into your hands—I never do. Increasingly it feels like an eternity, considering that *so* much could change in our country in three weeks based on recent events.

But I do know that it's important for us to be able to be vocal and to demonstrate and voice our opinions freely in our society, as long as they are not calling for "blood and soil."

I arrived in Paris in late July the day before the International AIDS Society's HIV Cure and Cancer Forum two-day pre-conference workshop (see page 36), so I was able to enjoy a couple of hours strolling the streets of the Marais district before going into full conference swing for the next five days. If you've never been to one of these confabs, the days are very full and start early in the morning and go late into the evening hours, for five consecutive days. For members of the media, there are also a number of press conferences each day, leaving little time to eat and barely enough time for bathroom breaks. Add in the innumerable side meetings that undoubtedly take place when advocates, researchers, and funders from all over the world are in one place at one time, and it can be mind-boggling when you are being pulled in several different directions at the same time, and you often will have to make a split-second decision as to what you are going to attend or participate in.

So this is where I found myself on the Monday of the conference, when I stopped in for the U=U community reception that evening, my last stop of the day before heading back to the hotel (see Michelle Simek's article on the U=U prevention campaign on page 22). The next thing I knew we were planning a demonstration for Wednesday morning, led by the one and only Charles King of Housing Works, with help from Canadian treatment activist Ron Rosenes, and an entire team of dedicated U=U supporters. When Charles asked if anyone had a boom box, I raised my hand and said I have a Bluetooth speaker, and that was it. I was in, and there was no going back.

I've taken part in demonstrations before, but it was fascinating to see how they have it down to a science. Speeches were well prepared, and we worked with the International AIDS Society communications office staff (who were amazing, by the way) down to the number of slides that the current presenter had left at the morning plenary, before we were to start descending the stairs to interrupt the session and seize control of the stage.

> **I've taken part in demonstrations before, but it was fascinating to see how they have it down to a science.**

Granted, it may take away some of the seeming "spontaneity" of a demonstration knowing there is all this planning involved, but it's done for obvious safety and security reasons, and the conference organizers generally don't prevent you from demonstrating, but just want to keep it safe and secure for everyone.

I was proud to be a part of the U=U demonstration at IAS 2017, to let people know about this great campaign started by Bruce Richman and now endorsed by hundreds of leading organizations around the world, which gets the information out to everyone that being undetectable, on treatment, and virally suppressed means you don't transmit the virus to others. It frees you from the chains and bondage of being seen as a vector of transmission, and into a human being with needs, wants, and desires just like anyone else.

Take care of yourself, and each other.

PHOTO: JOHN GRESS

BRIEFLY

ENID VÁZQUEZ @ENIDVAZQUEZPA

Newly approved hepatitis drugs mark a milestone in treatment and access

BY **ANDREW REYNOLDS**, PROJECT INFORM

The summer of 2017 will likely be remembered as a key moment in the history of treatment for hepatitis C (HCV), as two new treatments were approved by the FDA.

The Gilead Sciences HCV medication Vosevi (sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg) was approved on July 18 for the re-treatment of HCV in treatment-experienced people. Just two weeks later on August 3, the FDA approved the Abbvie medication Mavyret (glecaprevir 300 mg/pibrentasvir 120 mg) for the treatment of both treatment-naïve and treatment-experienced patients, including people living with HIV/HCV co-infection.

Both of these medications treat all genotypes (1–6), are taken once daily, and have very mild and manageable side effects.

Vosevi marks an exciting development for people who tried HCV treatment in the past but it didn't work.

Mavyret is highlighted by the fact that it only needs to be taken for 8 weeks (typical course of HCV treatment has been 12 weeks) for treatment-naïve patients. It is also another new option for treatment-experienced patients (with 12 weeks of treatment in this case).

Mavyret's 8-week option for treatment-naïve patients has the potential of being a real game-changer for people who may be perceived to have challenges with adherence (taking pills) due to its short duration.

Together, both medications mark a significant move forward in terms of who we can treat, how long we can treat, and most significantly, lower cost and greater access.

The AASLD/IDSA HCV Treatment Guidance recommends treatment for "all patients with chronic HCV infection, except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy." **We've reached a point in HCV treatment where we can say that there is almost nobody we can't cure.**

While the medications themselves are excellent scientific achievements, it's the cost of Mavyret that is most significant: $26,400 for 8 weeks and $39,600 for 12 weeks. With the addition of Medicaid discounts under the ACA, as well as agreements made with other insurers, this lower-cost treatment option has the potential of opening access to all.

All too often, patients and advocates are told the medications are too expensive to cover and will wipe out Medicaid budgets, denying people treatment and/or making them wait until their liver health worsens so as to be eligible. This price significantly weakens this argument.

Again, there is nobody we can't treat, and now we can afford to do it.

OI guidelines updated

U.S. guidelines for HIV opportunistic infections (OI) were updated July 28 to **"modernize some of the language and more closely reflect the standard of care in 2017"** for *pneumocystis* pneumonia (PCP) and *toxoplasma gondii* encephalitis. This includes getting people living with HIV onto treatment earlier rather than later in order to prevent these potentially deadly infections. There's also the possibility of stopping primary and secondary prevention strategies (such as medication) for those individuals taking HIV therapy who have undetectable viral loads and a T-cell count between 100 and 200. Criteria for being able to stop prophylaxis is provided. See the guidelines at aidsinfo.nih.gov.

Genvoya label updated

The drug label for Genvoya was updated in August to add data from nearly three years of study. At 144 weeks, Genvoya continued to fare as well as its predecessor, Stribild, in terms of efficacy and side effects. There was still a decrease in bone mineral density, but as expected, not as much with Genvoya compared to Stribild. Lipid increases were slightly higher with Genvoya. Steroid drug interactions were also updated. Go to fda.gov.

FDA grants review for biologics license to ibalizumab

Theratechnologies Inc. announced June 30 that its application for a biologics license for ibalizumab has

been accepted for review by the FDA. Ibalizumab (IBA) for HIV treatment has a mechanism of action that is unlike any other antiretroviral currently on the market. If approved, **it would also be the first HIV medication that doesn't need to be taken every day**. It is infused (via IV) once every two weeks. Combination therapy is still required, so that other HIV drugs will need to be taken as well.

The FDA set January 3, 2018 as the PDUFA (Prescription Drug User Act) date for its review.

Guidelines add TAF for hep B treatment

U.S. HIV treatment guidelines were updated in August to add Descovy for the treatment of hepatitis B. Descovy consists of emtricitabine and tenofovir alafenamide, or FTC/TAF. In addition, adefovir and telbivudine are no longer recommended as options for people co-infected with HIV and hepatitis B, due to limited safety and efficacy data for this group, as well as a higher incidence of toxicities. Moreover, data were added regarding fluoroquinolone resistance in *Shigella* isolates, including guidance on when to use the antibiotic for this infection. For more information, go to aidsinfo.nih.gov.

Prison doesn't deter drug problems

The Pew Charitable Trusts conducted an analysis which shows that putting people in prison for drug offenses doesn't lower the rate of drug use or overdose deaths. "**These findings reinforce a large body of prior research** that casts doubt on the theory that stiffer prison terms effectively deter drug use, distribution, and other drug-law violations. The evidence strongly suggests that policymakers pursue alternative strategies that research shows will work better and cost taxpayers less," Pew wrote in a letter to the President's Commission on Combating Drug Addiction and the Opioid Crisis, dated June 19. Go to pewtrusts.org/en/research-and-analysis/speeches-and-testimony/2017/06/pew-analysis-finds-no-relationship-between-drug-imprisonment-and-drug-problems.

HIVMA Medical Student Award winners

There's concern over whether there are enough medical students pursuing HIV care to meet future needs. In June, the HIV Medical Association (HIVMA) continued to encourage the development of new providers by **awarding 14 medical students with a three-year HIV research project grant**. They will be working under the auspices of a mentor specializing in HIV. The research projects chosen by the winners include transgender youth homelessness, street-based HIV treatment, and the cure. Go to hivma.org.

Grady/Atlanta earns Gilead award

"The Grady Health Foundation is pleased to announce a **$2 million donation from Gilead Sciences that will help fund a [modernization] of Grady Health System's Ponce de Leon Center,** which houses one of the nation's largest and most comprehensive programs for the treatment of advanced HIV and AIDS," the organization announced on June 28.

"Currently, Atlanta is the epicenter of the urgent HIV epidemic that has greatly impacted the Southern United States," Gilead Sciences reported in a press release. The pharmaceutical company's award supports the planned $23 million renovation. Grady Health Foundation noted that the center serves one out of four HIV patients in Georgia. Gilead produces some of the most commonly taken HIV medications in the country, including Truvada and Genvoya.

Penicillin shortage for syphilis

New York-based TAG (Treatment Action Group) is calling for people to sign on to a letter **demanding that Pfizer meet with community advocates to discuss the shortage of a syphilis medication**, Bicillin-LA. "The preferred antibiotic to cure syphilis in adults has only one manufacturer in the U.S.—and has become increasingly more difficult for health care providers to access because of a drug shortage that has lasted more than a year. The shortage is hitting at a critical time when syphilis rates are rising in the U.S., including rates of congenital syphilis [acquired at birth]," TAG reported in a July press release. Go to treatmentactiongroup.org/content/sign-letter-response-critical-shortage-penicillin-syphilis-treatment-us.

Free PrEP through study

Free PrEP and lab work is being provided through a government study **comparing an injectable drug taken once every two months against the only PrEP currently available on the market, Truvada**. The medication being studied, cabotegravir, has already

PENICILLIN: ISTOCKPHOTO

shown efficacy against HIV (see page 37). There are 37 sites enrolling participants; in the U.S., these include Aurora, Colorado; Birmingham, Alabama; Chicago; and New Orleans. Go to clinicaltrials.gov/ct2/show/NCT02720094.

Additional Walgreens clinics now offer PrEP

Walgreens announced that "providers at Walgreens Healthcare Clinic locations in **17 new markets will be able to prescribe PrEP** (pre-exposure prophylaxis), a medication protocol for people who don't have HIV to help proactively protect against HIV infection." The new locations include Cincinnati, Cleveland, Columbus (Ohio), Dallas, Denver, Kansas City, Knoxville, Las Vegas, Louisville, Memphis, Nashville, Orlando, Philadelphia, Phoenix, Tucson, Washington D.C., and Wichita.

Camp Heartland now 25

Camp Heartland, for children living with HIV or affected by it, is now 25 years old. "At Camp Heartland, the stigma stops. You can say as much or as little as you want about how HIV/AIDS impacts your life and no one will judge you. And **there's a sense of relief that comes with experiencing complete acceptance**." Go to oneheartland.org. Read a moving story about the camp at hivplusmag.com/youth/2017/7/14/youth-camp-kids-hiv-celebrates-its-25th-anniversary.

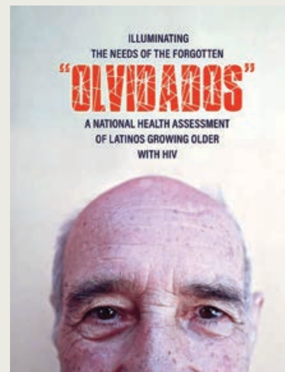
AIDS Run & Walk Chicago October 1

"Chicago-area residents will band together for equity and justice for individuals living with and vulnerable to HIV at the 16th annual AIDS Run & Walk Chicago on Sunday, Oct. 1," reports the AIDS Foundation of Chicago (AFC). "Funds raised through AIDS Run & Walk Chicago will **benefit programs and services for [AFC] and more than 30 other metropolitan organizations** that provide life-saving services to people living with HIV and AIDS. Since it was established in 2001, AIDS Run & Walk Chicago has netted more than $5 million to battle the epidemic." Sign up or donate at events.aidschicago.org/site/TR?fr_id=1420&pg=entry.

United Healthcare reverses itself on PrEP

NBC News reported that United Healthcare denied Truvada for PrEP to a New York man, writing in a July letter about the HIV prevention pill, "The information sent in shows you are using this medicine for high risk homosexual behavior." **The insurer approved the prescription about a month later, following protests by HIV advocates.** The letter also noted that the pill has an FDA approval "to reduce the risk of sexually acquired HIV-1 infection in adults at high risk," but this is not always necessarily true of PrEP (see page 26). "We apologize for the insensitive language appearing in the letter and regret any difficulty it caused," a spokesperson for the company wrote in an email to NBC News in early August. "We have corrected our letters, removed the prior authorization requirement for Truvada and members can fill their prescription at the network pharmacy of their choice." See nbcnews.com/feature/nbc-out/united-apologizes-reverses-truvada-policy-after-hiv-activists-push-back-n789801.

NEEDS OF HIV-POSITIVE OLDER LATINOS HIGHLIGHTED IN NEW REPORT



Concerned that the needs of Latinos age 50 and older who are living with HIV are not being addressed, the Latino Commission on AIDS and the Hispanic Health Network has issued what they say is the first report of its kind, highlighting the needs of "the Forgotten"—*los Olvidados*.

"Olvidados: A National Health Assessment of Hispanic/Latinos Growing Older with HIV" **surveyed 157 older Latinos in cities with high rates of HIV** on the mainland U.S. (New York, Los Angeles, Houston, and Miami) and in Puerto Rico (San Juan, Fajardo, and Camuy).

Among the report's findings:

- ONE IN THREE had some difficulty with adhering to treatment.
- ALTHOUGH 43% reported sexual activity within the last three months, they had not discussed sex with their primary care provider.
- 12% SAID they were in recovery for substance use.
- HALF OF RESPONDENTS reported experiencing depression.

The report calls for a number of culturally aware wellness initiatives and efforts to remove stigma, as well as a call for city, county, and state public health departments to address the needs of aging Latinos.

Although they make up 18% of the U.S. population, Latinos accounted for about 24% of new HIV diagnoses in 2015, according to the Centers for Disease Control and Prevention. In 2015, Latinos ages 50–54 had a rate of HIV diagnoses that was more than twice the rate of infection among their non-Latino white counterparts.

Gilead Sciences, the Hispanic Federation, and AIDS United helped fund the survey. The report can be downloaded at latinoaids.org/publications/olvidados-older-latinos-hiv-2017.pdf.

of the respondents indicated they had sex within the last 3 months and their sexual partners were:

LIVING WELL WITH HIV

Tips for living healthier and smarter, whether you're newly diagnosed or not

BY PETER SHALIT, MD, PHD

Let's say you just tested positive for HIV—now what?

We know that folks are healthier if their virus is treated and suppressed with medication, so it's standard practice now to start treatment as soon as you test positive. However, not everyone is able to start treatment right away. Here are some questions you might consider before making the commitment to treatment.

What's in it for me? Why should I take HIV medication?

STUDIES SHOW that people with HIV who take antivirals, regardless of their CD4 count or viral load, have fewer medical complications than those who leave their HIV untreated. These complications include not only conditions we think of as "HIV-related," such as various types of infections, but also other conditions such as heart attacks, strokes, and kidney and liver problems. In other words, having detectable amounts of this virus in your bloodstream is bad for you. In addition, successful treatment, with good suppression of the virus, makes it much less likely that you will transmit your HIV infection to a sexual partner or unborn child before or during childbirth.

Do I have a health care provider who is knowledgeable about HIV? Am I comfortable working with them on my health?

WHEN YOU first test positive, you may not already have a primary health care provider, or you may have one that is not an HIV expert. It's important to see an HIV expert for your care. In most U.S. cities there are a number of physicians, nurse practitioners, and physician assistants who do high-quality HIV treatment, and are nonjudgmental about HIV and other sensitive issues such as sexuality and recreational drug use, so you will probably have a choice. In rural areas it may be harder to find a suitable provider, so you may have fewer choices, and unfortunately you may have to travel some distance for health care.

Do I have health insurance that will pay the cost of medication and monitoring?

HIV TREATMENT is expensive. It's important to have insurance that will cover the treatment. Your

ILLUSTRATION: HILCH/ISTOCKPHOTO

costs may still be high, but there are many programs that can help cover some of the costs. (See the latest POSITIVELY AWARE HIV Drug Guide, or go to positivelyaware.com.) Since HIV treatment is a long-term commitment, it's important that treatment not be interrupted by lack of insurance or inability to pay.

Is my life situation stable—are there issues in my life that would get in the way of taking medications every day?

LIFE COMPLICATIONS such as an unstable living situation, difficult work situation, out-of-control substance use, or depression all can make it harder for a person to take medication every day. If your ship of life is sailing through rough seas, you may want to find some calmer waters before starting on HIV treatment.

I've heard there are so many drugs for HIV now, how do I decide what's the right treatment for me?

YOU CAN RESEARCH different treatments yourself, but it's easy to get overwhelmed. That's why it's good to have a trusted health care provider to sort through all the choices and recommend a treatment, or a few treatment choices, that may be best for you.

GENERAL HEALTH FOR FOLKS LIVING WITH HIV

BEING HEALTHY AND HIV-POSITIVE is not only about having an undetectable viral load. All the standard advice about healthy living applies to people with HIV, but having the virus means there are a few extra considerations.

DIET

WHOLE BOOKS HAVE been written about healthy diets. There's no special diet recommendation for people with HIV. There are a lot of fads out there, and even the research-based recommendations change from year to year. In general, though, unprocessed, fresh, or raw foods tend to be healthier than heavily processed foods. Also, we're learning that excess carbohydrates (sugars, starches, and alcohol) contribute to weight gain, so it's a good idea to avoid carbohydrate binges. There is no one study that definitively shows that multivitamin supplements have any particular health benefit for people with or without HIV; they are probably a waste of money. (Editor's note: Many advocates would argue otherwise. Author's note: I'd like to see the evidence from controlled studies that multivitamins improve health.) The one supplement that may be beneficial is vitamin D, which is important for strong bones. Many Americans are low in vitamin D, and bone strength can be an issue for people with HIV, so a vitamin D supplement (at least 2,000 IU per day) is not a bad idea.

EXERCISE

SOME PHYSICAL ACTIVITY every day is important. There is no one right way to add exercise to your daily routine—there are many ways. Some people devote a special time each day for pure exercise, such as lifting weights at the gym, swimming at the Y, or taking a 2-mile run before breakfast. But you don't have to be one of those people to still include exercise as part of your life. You can build it into your day by walking or bicycling instead of driving or taking the bus to work or to the store; using the stairs instead of the elevator; walking the dog; and so on. As the saying goes, "The best exercise is the one you do."

ILLUSTRATION: HILCH/ISTOCKPHOTO

VACCINES

FOLKS WITH HIV should have all the same vaccines as everyone else, with some extra stipulations. In particular, everyone with HIV should be immunized for hepatitis A and B. There are now vaccines for HPV (the virus that causes warts and some cancers). These are only approved for adolescents and people into their mid- to late 20s; however, some providers recommend the HPV vaccine to sexually active folks older than the approved age, and sometimes insurance will cover it. Pneumonia vaccines are recommended for everyone with HIV. One type is given at any age and a second type is approved for use after age 50. A vaccine for meningococcus (the bacterium that can cause a type of meningitis) is now recommended for all folks with HIV. Your health provider can and should make sure you are up-to-date with your immunizations.

MENTAL HEALTH

MODERN LIFE IS STRESSFUL. HIV can add additional stress. Especially the first weeks or months after getting an HIV diagnosis, you may need some help dealing with stress. There are many ways to do this. Exercise (see above) is a great way to burn off stress. It helps to have a confidant or advocate—a friend you can talk to about what you are experiencing, maybe accompany you to visits with your provider, and provide a hug when requested. Talking with a counselor or therapist can be helpful for some folks. Some cities have peer support groups for people with HIV. Spiritual practice is another way to reduce stress. If you find yourself struggling with stress and anxiety and you don't know where to turn, ask your health care provider.

RECREATIONAL DRUGS

SOME MIND-ALTERING substances are okay in moderation. These include alcohol as well as cannabis (marijuana), which is now legal in some parts of the U.S. The key is moderation. Other drugs are too dangerous to ever be okay. These include tobacco as well as "street drugs" such as meth, cocaine, and heroin. The negative effects of these drugs outweigh any short-term pleasure they may provide. Two that can be particularly harmful for people with HIV are tobacco and crystal meth. Tobacco is a major factor in many cancers (for example lung, throat, cervical, anal, and bladder) as well as heart and blood vessel disease, and people with HIV seem to be more susceptible to its harmful effects. Tobacco is extremely addictive but there are ways to quit, and it's worth it. More than half of Americans who have ever smoked have now quit. If you can't quit altogether, reducing the number of cigarettes you smoke each day is better than nothing. Crystal meth ruins lives, rots teeth, and damages brains, yet it can be very hard to stop once you get started. Better not to start in the first place, but if you have started and aren't yet ready to quit, there are places that can still help (such as a support group or other harm reduction program).

SEXUALITY

OFTEN THERE IS A LOT of discomfort discussing sexuality, but it's an important part of being human. HIV can impact a person's sexuality in many ways. It can make dating complicated ("When do I tell the other person I'm positive? Will they reject me?"), and there are concerns about transmitting the virus during sex. We are learning that people whose HIV is well suppressed are very unlikely to transmit their virus. [See "Undetectable Equals Untransmittable," page 22.] This is reassuring, but many people are not aware of this information, and so there is still much fear and potential rejection around negative-positive matchups.

HIV can also impact hormone levels. Men with HIV sometimes develop testosterone deficiency. Lack of testosterone in a man can cause low energy, lack of interest in sex, and depression; it can also speed up the loss of calcium from the bones. It is common for men with low testosterone to take testosterone replacement, given by shots or a daily application of testosterone-laced gel. This should be considered carefully because there are hints that testosterone replacement may increase a man's risk of a heart attack, and if a man

develops prostate cancer while taking testosterone, the cancer may progress faster.

Erectile dysfunction is another common problem for men, and has many causes. Smoking is probably the single biggest factor against erections in men middle-aged or older, followed by diabetes. Interestingly, testosterone is not required for erections; men with low testosterone, as well as transgender women who have a penis and are on female hormones, often have normal erections, while many men with erection problems have normal testosterone. Erectile dysfunction may be a barrier to safer sex, because condoms interfere with erectile function in some men. Medicines such as Viagra or Cialis can be very helpful in improving the quality and duration of a man's erection, and for some men it's the only way they can use a condom and still keep an erection. However, these medications have become very expensive and are typically not covered by insurance.

Folks who are sexually active outside of a mutually monogamous relationship run the risk of sexually transmitted infections (STIs) such as syphilis, hepatitis C, gonorrhea, and chlamydia, so it's important to be screened regularly. In some cases of syphilis or hepatitis C, the infection may be worse and progress more rapidly if you are HIV-positive. STI screening is an area where good communication with your health care provider is essential. It's also important to have a provider who is knowledgeable and nonjudgmental about the diagnosis and treatment of these conditions. So don't be shy about letting your provider know about your sex life. Part of your provider's job is to help ensure that you are able to have a satisfying sex life without causing yourself health complications.

REPRODUCTIVE HEALTH IS A PARTICULAR CONCERN for many HIV-positive women and men, both straight and gay. It is now possible, and reasonable, for HIV-positive people to reproduce and have uninfected babies, but this must be done with the guidance of a knowledgeable health care provider. It is helpful if the pregnancy is planned, so that the viral load of the parent(s) is undetectable from the start, and so that if one parent is negative, the act of conception does not put them at risk of getting HIV. The chance of the baby turning out to be HIV-positive is extremely low if the mom's virus is well suppressed during the pregnancy.

OTHER MEDICAL CONDITIONS

FOLKS WITH HIV are still susceptible to all the common conditions adults may get, such as high blood pressure, diabetes, heart disease, and cancer. The risk of some of these conditions is higher in people with HIV, so it is important to have regular monitoring, as well as preventive advice, by a primary care provider who is savvy about the health concerns of people with HIV. In addition, the medications used to treat or prevent these conditions may interact with anti-HIV meds. This is another reason to have an HIV-wise health care provider and, if possible, an HIV-savvy pharmacist. Two areas in particular are worth mentioning.

CARDIOVASCULAR DISEASE IS MORE COMMON, and sometimes occurs earlier, in people with HIV. Heart attacks and strokes can be prevented, or at least delayed, by working on lifestyle factors: exercise, careful diet, and not smoking. Studies have shown that quitting smoking is the single most impactful thing an HIV-positive smoker can do to prevent a heart attack. There are medicines that may be helpful for prevention as well.

SOME CANCERS ALSO OCCUR EARLIER, or more commonly, in people with HIV. For women, breast cancer screening is the same whether the person has HIV or not, but cervical cancer screening recommendations are stricter for HIV-positive women, because the cancer can progress more rapidly. Screening for colon cancer starting at age 50 has been shown to benefit everyone. For other cancers, screening is not as well proven and is more controversial. This includes cancers of the lung, prostate, and anus. Studies of screening and prevention for anal cancer are currently ongoing, although many providers are already performing anal pap tests to screen for possible precancerous changes in the area. It's best to talk to your provider for advice on cancer screening and prevention, but remember that the single most important thing a person can do to prevent cancer is to not smoke.

CONCLUSION

TESTING POSITIVE FOR HIV and being aware of your status is the first step in taking charge of your health and protecting your partner. Knowing the right questions to ask, and exploring areas where there may be room for improvement, can give you the tools you need to live longer and stronger with HIV. PA

PETER SHALIT, MD, PHD, AAHIVS, FACP, attended college at Cornell University in Ithaca, New York, then moved to Seattle where he obtained his PhD in Genetics from the University of Washington in 1981. He graduated from the University of Washington Medical School in 1985, but his involvement in HIV care started in the early 1980s while still in medical school. He practices general internal medicine and HIV care alongside two fabulous Physician Assistants in a private clinic in Seattle. Dr. Shalit is Clinical Professor of Medicine at the University of Washington School of Medicine and is involved in the training of health professionals and students in HIV care and the health care of sexual and gender minorities. He lives on Capitol Hill in Seattle with his husband and three cats.

NEXT STEPS

How to find a provider, knowing your rights, and more

BY ENID VÁZQUEZ

1 HIV TREATMENT

It's official: It's recommended that everyone with HIV be on antiviral therapy. It's been estimated that on treatment, people living with HIV will have a normal lifespan. Treatment also slows the progression from HIV infection to AIDS.

2 FIND AN HIV SPECIALIST

HIV is a relatively new, and complicated, medical condition. Look for an HIV specialist. **The American Academy of HIV Medicine and the HIV Medicine Association each have a provider finder.** Go to hivma.org and aahivm.org. In addition, your local AIDS service organization knows the HIV specialists in your area, and can help point you in the right direction.

3 MEDICAL CARE

Ideally, people with HIV should have a CD4+ T-cell count and HIV viral load measured every three to four months following suppression of HIV viral load with the use of therapy, although every six months and possibly yearly is generally accepted.

- The T-cell count is a measure of immune function.
- The viral load is a measure of viral function.
- Generally, the viral load is given greater weight.

4 BASELINE

At diagnosis or soon thereafter, **your clinic should check you for:**

- Other STIs
- HIV drug resistance
- Hepatitis B and C

5 INSURANCE

Just because you have health insurance doesn't mean that treatment is free. There are co-pays and other costs for medical care. (See the co-pay assistance chart in the PA HIV Drug Guide at positivelyaware.com.) For those without insurance, go to healthcare.gov, or call (800) 318-2596.

6 HIV AND THE ADA

How are people with HIV protected by the nation's disability law? Read the section on HIV from the Americans with Disabilities Act at ada.gov/archive/hivqanda.txt.

7 HIV ANTI-DISCRIMINATION LAW

The National Center for HIV Law and Policy protects human rights and covers several areas of concern (such as employment, housing, and immigration). Its website includes a link to organizations, by state, that can provide legal information to people living with HIV. Write the center: 65 Broadway, Suite 832, New York, NY 10006. Call (212) 430-6733. Go to hivlawandpolicy.org.

HIV PREVENTION

There are now more ways to prevent passing on HIV besides condoms and abstinence. Nothing is 100% guaranteed, however.

You can reduce the risk of transmitting HIV to a sex partner by nearly 100% by being on antiviral therapy with an undetectable HIV viral load (called "treatment as prevention," or TasP). See page 22.

Choosing to have sex only with other people who have the same HIV status as you is a prevention strategy called serosorting.

If you are HIV-positive, having HIV-negative sex partners who are on PrEP (pre-exposure prophylaxis) can greatly reduce the risk of transmission (with or without TasP).

If there is sexual exposure to the virus, and the HIV-negative partner is not on PrEP, they can take a 28-day course of pills to prevent infection, called PEP (post-exposure prophylaxis). **Medication must be started within 72 hours of exposure, and should be available in an ER.**

IMAGE: ISTOCK

UNDETECTABLE EQUALS UNTRANSMITTABLE

Groundbreaking prevention campaign takes the world by storm

BY **MICHELLE SIMEK**

“The messaging has to be consistent with the science...this will get us closer to the end of the epidemic.”

—**Bruce Richman,** Positive Access Campaign, *about U=U*

“**UNDETECTABLE = UNTRANSMITTABLE”** (otherwise known as U=U) has been on heavy rotation on most HIV/AIDS websites over the last several months. What exactly is U=U and what does it mean for the average person living with HIV (PLHIV)?

In a nutshell, U=U states that people living with HIV who are on antiretroviral therapy and have been undetectable (less than 40 copies in a milliliter of blood) for at least six months cannot infect others through sexual transmission.

But even after pivotal studies (see “The U=U Science” sidebar, page 24) reported this happy news, the message was not reaching the community and those who could most benefit.

Enter Bruce Richman, the founder of Prevention Access Campaign and its U=U campaign, a coalition of activists and AIDS service organizations (ASOs) who have taken on the mission of spreading the message of U=U across the globe to improve the lives of people living with HIV, dismantle HIV stigma, and advocate for universal access. Having worked in philanthropy, Richman developed cause-related campaigns and grant making programs for large companies and celebrities.

Richman is now dedicated to something that is “personally connected to me.” Diagnosed with HIV in 2003 at the age of 35, his thoughts went beyond himself: “How could I have sex again...I was worried about passing it on to others. I withdrew and didn’t have relationships.” It “took a while” to start medications—he didn’t start treatment until 2010.

In 2012, a condom broke during sexual activity and Richman “freaked out” and rushed to see his doctor at the time, Dr. Michael Wohfleiler in Miami. Dr. Wohfleiler told him that as long as he was undetectable, he could not transmit the virus to someone else and that this was called “Treatment as Prevention” (TasP).

While he trusted his doctor, he just “couldn’t believe that it was true.” He conducted his own extensive internet research and spoke with other doctors and scientists. The articles that he read were inconclusive and full of contradictions. Not to mention that there was no actual public health campaign about TasP that he could turn to. Richman continued to worry that he could infect someone else. He “had to figure out what was true for himself,” but then realized that he had a higher calling—“to figure out what was true for the HIV/AIDS community.”

When he came across the Swiss Statement (see sidebar), he read it, internalized it, and had a “new lease on life.” Richman became certain that he “could be with another person [sexually] without being afraid.”

But wait, was he the only person living with HIV who knew this? “Researchers didn’t know that no one in the community knew. It was fucking crazy.” So, he started the Prevention Access Campaign—and the controversy began.

STAGE DIRECTION: BRUCE RICHMAN (ABOVE, LEFT) AND U=U DEMONSTRATORS MAKE THEIR WAY TO THE STAGE AT IAS 2017.

PHOTO: ©MARCUS ROSE/IAS

Richman has been called "a danger to public health" and a "false prophet" to his face, via e-mail, and on social media. He also has been called a "one-man army," which he takes as a compliment. But when asked about it, he demurs politely and says that it is really people living with HIV all over the world who are the "true army." He's not a rock star, he's "a roadie…I'm not used to being that guy."

BENJAMIN YOUNG, MD, PHD, is a popular contributor to TheBody.com and Chief Medical Officer of the International Association of Providers of AIDS Care (IAPAC). Dr. Young firmly believes that the "scientific evidence is compelling—not a single documented case of transmission by someone who is on effective ART. While it is hard to prove 'zero' risk, the risk of transmission is extraordinarily low." Dr. Young firmly supports the World Health Organization (WHO) guidelines that call for antiretroviral therapy for everyone diagnosed with HIV, regardless of their T-cell count. WHO estimates that if their recommendations were to be adopted across the globe, they could prevent 21 million deaths and prevent 28 million new infections by the year 2030.

Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases (NIAID), calls the evidence "incontrovertible." When asked about the importance of U=U in the context of HIV/AIDS history, he replies, "With U=U we can theoretically end the epidemic. In a perfect world, if there was health care for all—in both the U.S. and resource poor nations—we could test, treat, and prevent transmission."

Proponents of U=U stress that HIV-positive people who are not undetectable should not be shamed or stigmatized. Not everyone in the U.S. has access to antiretrovirals, let alone in resource-poor countries. Additionally, complete viral suppression may not be possible for people who are resistant to many HIV medications. But they do hope that those who can access medications will use them and achieve viral suppression, both for their own health and that of others. And also spread the word to their sexual partners and other PLHIV.

But what about the naysayers? Those who don't believe in U=U or have concerns? Some were contacted and declined to comment. However, Gina Brown, an activist from New Orleans who is living with HIV, says, "In the beginning I had some reservations about this message. I wasn't really sure how it worked. To me it was almost too good to be true. I didn't want to give PLHIV the wrong information or information that could get them into trouble. (Louisiana is a state that criminalizes HIV.) You would think that I'd be an initial believer; after all, I had a daughter who was proof that treatment works. I was on 076 [the study demonstrating that giving AZT to pregnant moms and babies cut the risk of transmission by two-thirds], plus the fact I'd been in a relationship where we made a conscious decision to not use barriers and the guy never acquired HIV. I was undetectable during that time, as I am now. I happened to meet Bruce Richman in Florida at USCA [the U.S. Conference on AIDS] and we had

JUMP TO PAGE 25 >>

THE SCIENCE OF U=U

"UNDETECTABLE = UNTRANSMITTABLE" has been officially endorsed by many U.S. and international AIDS service organizations (ASOs), including AIDS United, Positive Lite, Canadian AIDS Treatment Information Exchange, APLA Health, GMHC, Housing Works, Human Rights Campaign, Desmond Tutu HIV Foundation, and the National Alliance of AIDS State & Territorial Directors.

Many HIV activists are applauding the prevention message, while others remain skeptical. Several respected national ASOs have declined to support the U=U campaign. Many people living with HIV are not so sure what it even is and how it might affect them.

To say that an undetectable viral load makes it virtually impossible to transmit the virus during sex is a bold and powerful statement. But only 6–14% of people who are living with HIV and are on treatment believe they cannot transmit the virus, according to AIDSMAP.

In January of 2008, the Swiss National AIDS Commission issued a statement co-authored by four of the country's experts, most notably Dr. Pietro Vernazza. It became known as the "**Swiss Statement**," which reads:

"An HIV-infected person on antiretroviral therapy with completely suppressed viraemia ("effective ART") is not sexually infectious, i.e., cannot transmit HIV through sexual contact." It went on to say that this statement was true as long as:

- **The person adheres to antiretroviral therapy, the effects of which must be evaluated regularly by the treating physician; and**
- **The viral load has been suppressed below the limits of detection (i.e., below 40 copies/ml for at least six months; and**
- **There are no other sexually transmitted infections (STIs).**

Not surprisingly, there was some backlash following this statement's release. It was considered controversial at the time and many HIV/AIDS advocates were skeptical of the data.

In 2016, final data from the HIV Prevention Trials Network (HPTN) 052 study were published by the *New England Journal of Medicine* (NEJM). During HPTN 052, approximately 1,736 serodiscordant (meaning that one sexual partner was HIV-negative, the other partner was HIV-positive), mostly straight couples (although there were 38 gay couples) were followed and the HIV-positive partners were given antiretroviral medications, some sooner and some later. The study took place in 18 sites in eight countries across the world.

HPTN 052 found a 93% reduction in HIV risk in those partners who had received HIV treatment earlier, rather than later. After viral suppression for six months, there were zero new infections. Dr. Myron Cohen, principal investigator for HPTN 052 and Director of the Institute for Global Health and Infectious Diseases at the University of North Carolina at Chapel Hill, was quoted as saying, "The HPTN 052 study confirms the urgent need to treat people for HIV infection as soon as it is diagnosed to protect their health and for public health."

On July 12, 2016, data from the PARTNER study were released in the *Journal of the American Medical Association* (JAMA). This study looked at 888 serodiscordant couples (38% of them were gay male couples, the rest were heterosexual), in 75 clinics in 14 European countries. The PARTNER study tracked 58,213 condomless sex acts (both anal and vaginal). Again, the HIV-positive sexual partner was on antiretroviral therapy for at least six months—and the study showed zero linked transmissions yet again. However, there were eleven new HIV infections among the HIV-negative partners, 10 in gay men and one in a straight couple. But these were not linked infections, and eight of the 11 participants reported that they had recent condomless sex with someone outside their main relationship.

And as this article was being written, new data were presented at the International AIDS Society Conference (IAS) 2017 in Paris. Opposites Attract, a study of serodiscordant MSM (men who have sex with men), took place in Australia, Brazil, and Thailand. More than 12,000 condomless anal sex acts were recorded among 343 couples. No linked HIV transmissions occurred when the HIV-negative partner was only protected by his HIV-partner's undetectable viral load.

But what exactly are "linked transmissions" in the context of a study? According to Dr. Anthony Fauci, head of the National Institute of Allergy and Infectious Diseases (NIAID), linked transmissions are those infections that are known to come from "regular sexual partners through genotypic tests… unlinked infections are not from the same person." Basically, study scientists run genotypic tests that can show whose virus came from whom.

—MICHELLE SIMEK

FROM PAGE 23 >>
an in-depth conversation about U=U. He told me where I could find credible information that would spell U=U out clearly. I devoured this information, joined the U=U Facebook page and became a member of the U=U Steering Committee. I am a true believer that if a PLHIV is undetectable they cannot transmit the virus. That's why it's important that *every* PLHIV have access to this information and the medications that makes U=U a possibility in their lives!"

U=U is considered fact by most, and still fiction by a smaller number of PLHIV, advocates, and health care workers. However, there is nothing wrong with a healthy debate and both sides can learn from the opposing perspective. Says writer Bob Leahy, "There are good conversations to be had on how U=U represents both a great opportunity and something of a challenge for some [people]." Let us start those conversations now. PA

MICHELLE SIMEK works at an HIV/AIDS research and treatment clinic in Los Angeles, California. She is also an actor, freelance writer, and literary editor. In her spare time, she knits, goes to punk rock shows, and pets her cat, Baxter.

STAGE PRESENCE: BRUCE RICHMAN DELIVERS A STATEMENT DURING THE U=U PROTEST AT IAS 2017.

WHAT THEY SAY ABOUT UNDETECTABLE = UNTRANSMITTABLE

BOB LEAHY
PUBLISHER AND WRITER, POSITIVELITE.COM

"There really is no room for skepticism. Science is science. The difficulties I see with people not accepting the campaign's message involve people still coming to grips with the issues that the science presents, particularly to the marginalized."

MARIA MEJIA
U=U NATIONAL AND INTERNATIONAL STEERING COMMITTEES MEMBER

"I am a 29-year survivor of HIV. I have been undetectable for 18 years...if anyone takes their medications and has a sustained undetectable viral load we *cannot* transmit HIV! I consider this one of the most important anti-stigma campaigns everywhere I go and speak."

BENJAMIN YOUNG, MD, PhD
CHIEF MEDICAL OFFICER OF THE INTERNATIONAL ASSOCIATION OF PROVIDERS OF AIDS CARE

"[The] scientific evidence is compelling—not a single documented case of transmission by someone who is on effective ART. While it is hard to prove 'zero' risk, the risk of transmission is extraordinarily low."

GINA BROWN
ACTIVIST

"I am a true believer that if a PLHIV is undetectable they cannot transmit the virus. That's why it's important that every PLHIV have access to this information and the medications that makes U=U a possibility in their lives!"

DR. ANTHONY S. FAUCI
DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

"HIV-positive people aren't dangerous to anybody, it just isn't so. Transmission is not completely impossible, but an overwhelming amount of data states that it is almost impossible."

RICHMOND: ©MARCUS ROSE/IAS • MEJIA: SEAN BLACK • BROWN: DAYMON GARDNER • FAUCI: ©MARCUS ROSE/IAS

GOODBYE TO 'RISK'

Watch your words. Lose the labels if you want to prevent HIV

BY ENID VÁZQUEZ

Risky business.
Risk taker.
High risk.

That's not how people want to be seen when it comes to HIV. In the epidemic, the word "risk" is associated with the notion of "doing something wrong."

So using the words "at risk" becomes risky in itself. It runs the risk of turning people off, and away from prevention messages. People may not avail themselves of condoms or PrEP (the HIV prevention pill) if they don't identify with risk.

If they don't identify with HIV risk, they don't identify with HIV prevention.

While "risk" tends to blame behavior (as in "taking risks"), "vulnerability" may more accurately express the reality. There are many things that can make people vulnerable to HIV, including their environment—not necessarily their behavior.

"I find that people struggle with labels, no matter what the label is," says Gabriela Zapata-Alma, Program Director for Substance Use Treatment at Thresholds, a mental health organization in Chicago for people with low incomes. "Especially because different labels mean different things to different people."

"It's about stigma," she says. "Whatever word we use as a label is stigmatizing and then people reject the stigma."

"I like to frame things in the positive whenever possible," she says. "For example, 'What are you doing to protect your sexual health?' Then we can discuss the gaps. I'll ask questions. 'Have you heard of PrEP?' 'What are your thoughts on PrEP?' "

Risk and vulnerability may be very similar, but "might you be vulnerable?" may be taking a softer approach that makes people more comfortable. Even then, a label's a label. Zapata-Alma remembers when a client became angry after she said to him, "It sounds like you're feeling vulnerable." He yelled, "I'm not vulnerable!"

ONE WAY OR ANOTHER, however, HIV prevention messages need to be made.

Years ago, when Dr. Thomas Klein of Klein and Associates in Chicago asked a patient if he wanted to go on PrEP, the patient said he wasn't at risk but would think about it.

Three months later the young man returned and was HIV-positive.

How, if he wasn't "at risk"?

Dr. Klein agrees that the word "risk" doesn't work well—" 'vulnerability' is much less of a negative term," he says. "That may be a way to get through people's barriers. You just have to put it in a different way."

He asks his HIV-negative gay male patients, "Have there been any times in the last year when you've had unprotected anal sex with someone?"

"If they say 'Yeah, but only once or twice,' then I say, 'You really need to consider PrEP, because all you need is that once or twice.' "

One patient on PrEP stopped it when he entered into a relationship, but then went out one night and met someone. He became HIV-positive.

There's also the issue of sexual assault. Dr. Klein says that in addition to PrEP, more attention needs to be given to PEP (post-exposure prophylaxis). PEP is the use of medication for one month following a possible exposure to HIV. PEP is highly effective at preventing HIV infection, but he said too many people are still unaware of it. It must be started within 72 hours of exposure.

He also tells his patients about Treatment as Prevention (or TasP, page 22).

"I think it is important to have those disclaimers, that if you know you're having sex with someone who has HIV but is undetectable, all the studies have shown

PHOTO: DAN BUJOREANU/ISTOCKPHOTO

that they're not going to pass on the virus," he says.

Of note, the CDC uses "condomless sex" to refer to sex without a condom, as sex with the protection of PrEP or TasP is not considered unprotected.

AT TPAN, the non-profit, community-based organization that publishes POSITIVELY AWARE, people who come in for HIV testing also often disassociate from the word "risk." They will say they're not at risk, but then check off all of the risk boxes: *Had sex while intoxicated or high. Had sex with person of unknown HIV status. Had an STI diagnosis. And so on.*

"Sometimes they identify with 'risk,' because they like to do what they do, and sometimes they don't," says Aquea Wynn, Prevention Manager at TPAN. "A lot of times we get blown off. 'Oh, yeah. This is only a one-time deal.' Then we see that they've been here before for the same reason, or a couple of times."

She talks about stages of change, of "being ready to do what they need to do to keep them and their partner safe. Being ready to allow us to help them get there." TPAN provides interventions, such as counseling and referrals to PrEP.

"People have their own definition of what risk means," adds Wynn. "Different partner. Share needles. Don't use condoms. Use condoms sometimes. We have to ask open-ended questions. 'So, what do you do to protect yourself from HIV?' Because if you ask a close-ended question, people don't tell you jack."

She notes another reason why "risk" is burdensome: the fatigue factor.

"A lot of people feel a level of shame because they saw their friends taken out by the epidemic, shame for being gay, bisexual, IDVU [intravenous drug user]. All those days of being inundated with *risk, risk, risk,* so after a while, you don't want to hear that any more! We have to find new ways of saying the same thing and help people connect with where they're at. Because the message is the same," says Wynn.

She adds that culture, however, becomes important. "Black gay men don't like the term 'barebacking.' That's white terminology to them. They say 'raw.' That's why 'what do you do?' is so important. You don't just give them a cheat sheet of what the CDC came up with."

HAVE THERE BEEN ANY TIMES IN THE LAST YEAR WHEN YOU'VE HAD UNPROTECTED ANAL SEX WITH SOMEONE?

If they say, 'Yeah, but only once or twice,' then I say, 'You really need to consider PrEP, because all you need is that once or twice.'

DAZÓN DIXON DIALLO, Executive Director of Sister Love in Atlanta and an international activist who works in South Africa as well, says she early on realized that, "Not everything that creates an opportunity for HIV acquisition is an active decision."

"So then the question becomes, how do you ascertain HIV acquisition *opportunity*," she continues, "a situation where a substantial opportunity for HIV acquisition is more related to the conditions in your life, such as where you live." Many people, for example, don't know about the effects of higher community viral load or greater incidence of HIV where they live and choose their partners.

"Understanding those things is actually getting the message across better than the idea that, 'If you're doing this or that, you're at greater risk.' " She says this is especially true when people are emotionally or economically needy, or otherwise dependent on others. "That's a vulnerability," she says. When educating women on risk factors for HIV, many will say, "Oh, I didn't know that a lot of these things were risky."

She finds that some people see the risks in their community or their social groups, but don't believe it can happen to them.

"There are women, and some young gay men," she says, "who see that their friend is with a man who cheats, or is needle sharing, or transacting sex for favors or money. But 'that would never be my man.'

"I just think that people make concessions based on their own comfort level," she explains. "And based on their own knowledge, which is still pretty low for most folks. They make concessions based on stigma around HIV and risk, because it's also denial. 'Yeah, I might be doing these things, but it's not as bad as what I see.' That sense of denial and that concession of 'not me' creates more vulnerability than it does risk taking."

Then there's the degree of risk perceived. "I've had people say, 'I may be at risk, but I don't think I'm at risk enough to take a pill every day.' Or they say, 'Well, I only had three boyfriends last year and I only had unprotected sex with one of them.' So that's different from, 'I had 10 partners and I had no protected sex,' " she explained.

"All the science tells us that young black gay men do not have more unprotected sex than anyone else," she adds. "It's just that who they are and where they are gives them a greater opportunity to get HIV than anybody else. Especially if they have, for example, more trauma. If they get kicked out of their home. If their masculinity is questioned every day of their life. Because they're black, they're at more risk for going to prison any given day. That vulnerability has more weight in those young men's lives than how many times they have unprotected sex."

DR. DAWN SMITH, Medical Officer for the CDC's Division of HIV/AIDS Prevention, says that, " 'Risk' is a term that applies to behaviors that may expose and infect a person with HIV. It is also applied to groups of people that engage in behaviors that confer risk of HIV exposure. For example, people who inject drugs (PWID) are a population at higher risk of HIV infection through sharing needles or other injection equipment. With this definition of 'risk' in mind, CDC testing, counseling and education materials focus on identifying the risk of specific behaviors people may engage in, instead of defining the individuals themselves as 'at risk.' "

"In contrast," says Dr. Smith, "the term 'vulnerability' is used to define situations in which HIV exposure is likely. Nearly anyone can be infected with HIV if exposed sexually or through injection drug use. Therefore, we are all biologically vulnerable to infection."

Clearly, "risk" is still good shorthand terminology for those who understand HIV risk factors well.

For those who don't, it's a loaded word. It helps create an environment where people cannot discuss their behavior, or downplay it. Even to themselves.

"That's why I think PrEP is important from a vulnerability standpoint, because it is a prophylactic," says Dixon Diallo. "You don't have to think about taking risk, you only have to consider that anything can happen, so I need to take this." PA

WHAT IS ODEFSEY®?

ODEFSEY is a 1-pill, once-a-day prescription medicine used to treat HIV-1 in people 12 years and older. It can either be used in people who are starting HIV-1 treatment, have never taken HIV-1 medicines before, and have an amount of HIV-1 in their blood ("viral load") that is no more than 100,000 copies/mL, or in people who are replacing their current HIV-1 medicines and whose healthcare provider determines they meet certain requirements. These include having an undetectable viral load (less than 50 copies/mL) for 6 months or more on their current HIV-1 treatment. ODEFSEY combines 3 medicines into 1 pill taken once a day with a meal. ODEFSEY is a complete HIV-1 treatment and should not be used with other HIV-1 medicines.

ODEFSEY does not cure HIV-1 infection or AIDS. To control HIV-1 infection and decrease HIV-related illnesses, you must keep taking ODEFSEY. Ask your healthcare provider if you have questions about how to reduce the risk of passing HIV-1 to others. Always practice safer sex and use condoms to lower the chance of sexual contact with body fluids. Never reuse or share needles or other items that have body fluids on them.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about ODEFSEY?

ODEFSEY may cause serious side effects:

- **Worsening of hepatitis B (HBV) infection.** ODEFSEY is not approved to treat HBV. If you have both HIV-1 and HBV and stop taking ODEFSEY, your HBV may suddenly get worse. Do not stop taking ODEFSEY without first talking to your healthcare provider, as they will need to monitor your health.

Who should not take ODEFSEY?

Do not take ODEFSEY if you take:

- **Certain prescription medicines for other conditions.** It is important to ask your healthcare provider or pharmacist about medicines that should not be taken with ODEFSEY. Do not start a new medicine without telling your healthcare provider.
- **The herbal supplement** St. John's wort.
- **Any other medicines to treat HIV-1 infection.**

What are the other possible side effects of ODEFSEY?

Serious side effects of ODEFSEY may also include:

- **Severe skin rash and allergic reactions.** Skin rash is a common side effect of ODEFSEY. Call your healthcare provider right away if you get a rash, as some rashes and allergic reactions may need to be treated in a hospital. Stop taking ODEFSEY and get medical help right away if you get a rash with any of the following symptoms: fever, skin blisters, mouth sores, redness or swelling of the eyes (conjunctivitis), swelling of the face, lips, mouth, or throat, trouble breathing or swallowing, pain on the right side of the stomach (abdominal) area, and/or dark "tea-colored" urine.
- **Depression or mood changes.** Tell your healthcare provider right away if you: feel sad or hopeless, feel anxious or restless, have thoughts of hurting yourself (suicide) or have tried to hurt yourself.
- **Changes in liver enzymes.** People who have had hepatitis B or C or who have certain liver enzyme changes may have a higher risk for new or worse liver problems while taking ODEFSEY. Liver problems can also happen in people who have not had liver disease. Your healthcare provider may do tests to check your liver enzymes before and during treatment with ODEFSEY.
- **Changes in your immune system.** Your immune system may get stronger and begin to fight infections. Tell your healthcare provider if you have any new symptoms after you start taking ODEFSEY.
- **Kidney problems, including kidney failure.** Your healthcare provider should do blood and urine tests to check your kidneys. Your healthcare provider may tell you to stop taking ODEFSEY if you develop new or worse kidney problems.
- **Too much lactic acid in your blood (lactic acidosis),** which is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat.
- **Severe liver problems,** which in rare cases can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark "tea-colored" urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain.
- **Bone problems,** such as bone pain, softening, or thinning, which may lead to fractures. Your healthcare provider may do tests to check your bones.

The most common side effects of rilpivirine, one of the medicines in ODEFSEY, are depression, trouble sleeping (insomnia), and headache.

The most common side effect of emtricitabine and tenofovir alafenamide, two of the medicines in ODEFSEY, is nausea.

Tell your healthcare provider if you have any side effects that bother you or do not go away.

What should I tell my healthcare provider before taking ODEFSEY?

- **All your health problems.** Be sure to tell your healthcare provider if you have or have had any kidney, bone, mental health (depression or suicidal thoughts), or liver problems, including hepatitis virus infection.
- **All the medicines you take,** including prescription and over-the-counter medicines, vitamins, and herbal supplements. Other medicines may affect how ODEFSEY works. Keep a list of all your medicines and show it to your healthcare provider and pharmacist. Ask your healthcare provider if it is safe to take ODEFSEY with all of your other medicines.
- **If you are pregnant** or plan to become pregnant. It is not known if ODEFSEY can harm your unborn baby. Tell your healthcare provider if you become pregnant while taking ODEFSEY.
- **If you are breastfeeding** (nursing) or plan to breastfeed. Do not breastfeed. HIV-1 can be passed to the baby in breast milk.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Please see Important Facts about ODEFSEY, including important warnings, on the following page.

Ask your healthcare provider if ODEFSEY is right for you.

ODEFSEY does not cure HIV-1 or AIDS.

SHOW YOUR RADIANCE

ODEFSEY is **a complete, 1-pill, once-a-day HIV-1 treatment** for people 12 years and older who are either new to treatment and have less than 100,000 copies/mL of virus in their blood or people whose healthcare provider determines they can replace their current HIV-1 medicines with ODEFSEY.

Odefsey®

emtricitabine 200mg/rilpivirine 25mg/
tenofovir alafenamide 25mg tablets

(oh-DEF-see)

IMPORTANT FACTS

This is only a brief summary of important information about ODEFSEY® and does not replace talking to your healthcare provider about your condition and your treatment.

MOST IMPORTANT INFORMATION ABOUT ODEFSEY

ODEFSEY may cause serious side effects, including:

- **Worsening of hepatitis B (HBV) infection.** ODEFSEY is not approved to treat HBV. If you have both HIV-1 and HBV, your HBV may suddenly get worse if you stop taking ODEFSEY. Do not stop taking ODEFSEY without first talking to your healthcare provider, as they will need to check your health regularly for several months.

ABOUT ODEFSEY

- ODEFSEY is a prescription medicine used to treat HIV-1 in people 12 years of age and older who have never taken HIV-1 medicines before and who have an amount of HIV-1 in their blood ("viral load") that is no more than 100,000 copies/mL. ODEFSEY can also be used to replace current HIV-1 medicines for some people who have an undetectable viral load (less than 50 copies/mL), have been on the same HIV-1 medicines for at least 6 months, have never failed HIV-1 treatment, and whose healthcare provider determines that they meet certain other requirements.
- **ODEFSEY does not cure HIV-1 or AIDS.** Ask your healthcare provider about how to prevent passing HIV-1 to others.

Do NOT take ODEFSEY if you:

- Take a medicine that contains: carbamazepine (Carbatrol®, Epitol®, Equetro®, Tegretol®, Tegretol-XR®, Teril®), dexamethasone (Ozurdex®, Maxidex®, Decadron®, Baycadron™), dexlansoprazole (Dexilant®), esomeprazole (Nexium®, Vimovo®), lansoprazole (Prevacid®), omeprazole (Prilosec®, Zegerid®), oxcarbazepine (Trileptal®), pantoprazole sodium (Protonix®), phenobarbital (Luminal®), phenytoin (Dilantin®, Dilantin-125®, Phenytek®), rabeprazole (Aciphex®), rifampin (Rifadin®, Rifamate®, Rifater®, Rimactane®), or rifapentine (Priftin®).
- Take the herbal supplement St. John's wort.
- Take any other HIV-1 medicines at the same time.

HOW TO TAKE ODEFSEY

- ODEFSEY is a complete 1-pill, once-a-day HIV-1 medicine.
- Take ODEFSEY with a meal.

GET MORE INFORMATION

- This is only a brief summary of important information about ODEFSEY.
  Talk to your healthcare provider or pharmacist to learn more.
- Go to ODEFSEY.com or call 1-800-GILEAD-5
- If you need help paying for your medicine, visit ODEFSEY.com for program information.

POSSIBLE SIDE EFFECTS OF ODEFSEY

ODEFSEY can cause serious side effects, including:

- Those in the "Most Important Information About ODEFSEY" section.
- Severe skin rash and allergic reactions.
- Depression or mood changes.
- Changes in liver enzymes.
- Changes in your immune system.
- New or worse kidney problems, including kidney failure.
- Too much lactic acid in your blood (lactic acidosis), which is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat.
- Severe liver problems, which in rare cases can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark "tea-colored" urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain.
- Bone problems.

The most common side effects of rilpivirine, one of the medicines in ODEFSEY, are depression, trouble sleeping (insomnia), and headache.

The most common side effect of emtricitabine and tenofovir alafenamide, two of the medicines in ODEFSEY, is nausea.

These are not all the possible side effects of ODEFSEY. Tell your healthcare provider right away if you have any new symptoms while taking ODEFSEY.

Your healthcare provider will need to do tests to monitor your health before and during treatment with ODEFSEY.

BEFORE TAKING ODEFSEY

Tell your healthcare provider if you:

- Have or have had any kidney, bone, mental health (depression or suicidal thoughts), or liver problems, including hepatitis infection.
- Have any other medical condition.
- Are pregnant or plan to become pregnant.
- Are breastfeeding (nursing) or plan to breastfeed. Do not breastfeed if you have HIV-1 because of the risk of passing HIV-1 to your baby.

Tell your healthcare provider about all the medicines you take:

- Keep a list that includes all prescription and over-the-counter medicines, vitamins, and herbal supplements, and show it to your healthcare provider and pharmacist.
- Ask your healthcare provider or pharmacist about medicines that should not be taken with ODEFSEY.

GILEAD

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SAFER DRUG CONSUMPTION SPACES: AN IDEA WHOSE TIME HAS COME

BY **ANDREW REYNOLDS**, PROJECT INFORM

What if you were told that there was a public health intervention that did the following for people who use drugs (PWUD):

1. Eliminate drug overdose deaths;
2. Reduce risk of HIV, hepatitis B, and hepatitis C transmissions;
3. Reduce risk for abscesses, bacterial infections, and endocarditis;
4. Provide a gateway for entry to drug treatment, medical care, and social services;
5. Reduce public injecting;
6. Reduce discarded syringes and other injection-related litter in the community;
7. Improve both individual health and public health;
8. Does all of the above while saving money.

Would you be interested in such an intervention? The answer is likely 'yes, but what could possibly do all of that?' The answer: Safer drug consumption spaces.

Safer drug consumption spaces (or SCS, for the purposes of this article), also known as safe injection facilities, safe consumption services, supervised consumption spaces, or drug consumption rooms, are professionally supervised spaces where people can inject, smoke, or snort pre-obtained drugs in a quiet, clean, and safe environment.

In the United States, this sounds like a radical idea, but SCS are well established throughout the world. In an effort to address problems associated with injection drug use, the first legal supervised consumptions space was established in Berne, Switzerland in 1986. Soon thereafter, others were opened in cities throughout Western Europe, with one in Sydney, Australia and two operating in Vancouver, Canada. Additionally, Canada is embarking on an expansion of SCS, with several planned to open across the country in the coming months and years.

Overall, there are approximately 100 SCS operating around the world, located in over 66 cities in 10 countries.

There are currently no legal SCS operating in the U.S.

The International Drug Policy Consortium defines drug consumption rooms (DCRs) as:

"protected places used for the consumption of pre-obtained drugs in a non-judgmental environment and under the supervision of trained staff. They constitute a highly specialized drugs service within a wider network of services for people who use drugs, embedded in comprehensive local strategies to reach and fulfill a diverse range of individual and community needs that arise from drug use.

"The aim of DCRs is to reach out to, and address the problems of, specific high-risk populations of people who use drugs, especially injectors and those who consume in public. These groups have important health care needs that are often not met by other services and pose problems for local communities that have not been solved through other responses by drug services, social services or law enforcement."

The European Monitoring Centre for Drugs and Drug Addiction adds that these sites "also seek to contribute to a reduction in drug use in public places and the presence of discarded needles and other related public order problems linked with open drug scenes. Typically, drug consumption rooms provide drug users with sterile injecting equipment, counseling services before, during and after drug consumption, emergency care in the event of an overdose and primary medical care and/or medical care and referral to appropriate social health-care and addiction treatment services."

There are many types of SCS. The most common one is the "integrated" SCS, where safe consumption spaces are made available along with a wide array of other services including, but not limited to, HIV and HCV testing, medical care, mental health services, and linkage to drug treatment. >>

THE BENEFITS OF SCS

Drug use and cessation

ON THE SURFACE it may seem counter intuitive that SCS will reduce drug use, but SCS do not encourage or increase drug use in their communities. Research has not found that the existence of SCS leads people to transition into injection drug use. People who use SCS are usually people who have injected drugs before.

SCS also lead PWUD into drug treatment and drug cessation. SCS serve as a low-threshold location for people to come and use drugs and receive other services, including referrals to drug treatment. Drug treatment is not mandated, nor is it even the ultimate endpoint. Keeping PWUD alive, healthy, and safe comes first.

That said, this compassionate approach and non-judgmental provision of services has a healthy impact on drug use. Insite, a SIF in Vancouver, has a drug treatment program on the floors above it. One study showed that 57% of PWID using Insite entered drug treatment, with nearly 1 in 4 (23%) stopping injection drug use entirely.

Eliminating drug overdose

WITH MILLIONS of injections and other forms of taking drugs, no one has ever died of a drug overdose in an SCS. SCS have trained peers, social workers, and medical staff who can respond to an overdose immediately. SCS also provide safer injection education. Additionally, SCS provide a quiet and calm space for PWUD to take their time, carefully prepare their drug and not rush, thus controlling and often moderating their drug dose.

In addition, cities such as Vancouver and Sydney saw significant reductions in overdoses, emergency calls, and hospital admissions in local communities following the opening of SCS. In Western Europe, other cities report the same.

Preventing HIV and hepatitis C

IN AN SCS, people never have to share anything. Studies have shown that participants are also less likely to share injection equipment in the community. The impact on reducing new infections is dramatic: Insite is estimated to have prevented over 1,100 new HIV infections over 10 years of operation. Other studies have modeled reductions in HCV infections as well.

Other injection-related medical consequences—abscesses, endocarditis, and other types of infections and wounds—are also reduced.

With all of these reductions in new HIV and HCV infections, as well as other medical problems, come reductions in cost and use of medical and emergency services.

Social issues

SCS PROVIDE indoor spaces, thus taking people off the streets, alleys, public parks, and public bathrooms to inject or smoke. Research has shown that public injecting decreases with an SCS, as does the number of discarded syringes and other injection paraphernalia. In addition, SCS do not lead to an increase in crime, including drug dealing and property crimes.

Sources: Drug Policy Alliance; "Safer Drug Consumption Spaces: A Strategy for Baltimore City," The Abell Foundation; "Alternatives to Public Injecting," Harm Reduction Coalition

The "specialized" model is one where only injecting or smoking of drugs happens. Staff is available to monitor for drug overdose and provide referrals to other programs and services.

In addition to these brick-and-mortar spaces, there are two types of mobile or temporary "pop-up" spaces for safer drug consumption, which locate themselves in places where PWUD live and follow them as homeless camps move or drug scenes shift.

CRITICS OF SCS contend that they enable and encourage drug use. They argue that PWUD won't use them, and that SCS will have little impact on preventing HIV, HCV, or overdoses. They worry that bringing them into neighborhoods will lead to public disorder problems, including but not limited to, loitering and crime, while doing little to address public drug use. They argue that tax dollars are better spent on law enforcement and drug treatment. In short, they argue that SCS won't work.

The facts, however, do not support such conclusions. These sites are well evaluated and are evidence-based interventions to improve the health of PWUD and have positive benefits for the communities where they exist. The benefits include improved access to clean syringes and improved disposal of used syringes; reduction in overdose morbidity and mortality; reductions in HIV and HCV infections; reductions in soft tissue infections and other medical complications from injecting; increased linkage to substance use treatment programs; and fewer public order issues (public nuisance, petty crime, and public drug use, etc.).

This is not to suggest that SCS will solve every problem associated with substance use, but they will minimize them. Additionally, SCS alone cannot address the problems associated with drug use, including poverty, racism, homelessness, or past trauma. SCS are most effective when they are a part of an integrated system of services to meet the complex needs of many PWUD.

COST EFFECTIVENESS models have shown these sites to save millions of dollars in medical expenses. They have a demonstrated impact on reducing new HIV infections (there is no current research on direct reduction of HCV), and models have demonstrated the potential to reduce new HIV and HCV infections in the long-term. Mathematical models estimating the potential for reducing new HIV and HCV infections in Montreal project that there would be 14–53 fewer HIV infections and 84–327 fewer HCV infections annually per jurisdiction.

In the U.S., models have shown that SCS have the potential for significant cost-savings. Alex Kral and colleagues published a paper that the opening of a single, 13-seat SCS would save $3.5 million per year while only costing $2 million. These savings would be the result of preventing approximately 3 cases of HIV, 19 cases of HCV, and preventing 415 days of hospital stays as a result of abscesses and other injection-related medical problems. Additionally, it would lead to 110 people entering opioid substitution therapy such as methadone, buprenorphine, etc.

A similar study in Baltimore demonstrated even more savings: $7.8 million in savings versus $1.8 million in costs. It showed that an SCS in Baltimore would result in preventing over 3 HIV infections and 21 HCV infections, and prevent 374 days in a hospital. This study also demonstrated reductions in ambulance calls, preventing 108 overdose-related calls as well as preventing 78 hospitalizations. Finally, it would link 121 PWUD into drug treatment.

The Safe Consumption Space movement in the U.S.

AMONG HARM REDUCTIONISTS and people who use drugs, there has been a desire to open SCS for many years. The dominant narrative regarding substance use in the U.S. war on drugs is one where people who use illicit

SAFETY FIRST: LOCATED IN VANCOUVER, CANADA, INSITE (ABOVE) IS THE FIRST LEGAL SUPERVISED DRUG INJECTION SITE IN NORTH AMERICA.

PHOTO: LAURA THOMAS, DRUG POLICY ALLIANCE

drugs are viewed as morally deficient individuals engaging in criminal activity, and that the only way to deal with "these people" is through abstinence-only drug treatment and/or incarceration. In this mind-set, there is little room for harm reduction and alternative forms of dealing with drug use, including SCS.

To help reshape the narrative on people who use drugs, and implement effective solutions to problems associated with drug use, a number of organizations, activists, and scholars are working on a variety of issues and projects, including SCS. Drug-user unions like VOCAL-New York and their counterparts in Washington, the San Francisco Drug Users Union, and Urban Survivors Union, have placed a high priority on the opening of SCS in their communities, and engage in community education and advocacy to help make them happen.

Policy organizations such as the Drug Policy Alliance, Harm Reduction Coalition, and Project Inform work with communities, local and state legislators, and other policy groups to include SCS in advocacy agendas geared to overdose prevention, HIV and HCV prevention, and access to drug treatment.

Finally, researchers such as Alex Kral of RTI International, Peter Davidson of University of California, San Diego, and Susan Sherman of Johns Hopkins are studying the cost effectiveness of SCS, as well as modeling their impact on preventing overdose and infectious disease.

Conclusion

SAFE CONSUMPTION SPACES are a proven, evidence-based intervention that have been shown to reduce overdose deaths, HIV and hepatitis C infections, and other medical problems, while at the same time improving the public order and quality of life of all people—both drug users and non-drug-using neighborhood residents. They are well established throughout the world, and they continue to expand to new countries as well. There is significant momentum to open SCS in the United States. There is a long way to go, but opening SCS in this country would be a strong response to people negatively affected by the war on drugs, saving lives and improving community life for all. PA

ANDREW REYNOLDS is the Hepatitis C Education Manager at Project Inform, and facilitates several HCV support groups in the San Francisco Bay Area. He's also a counselor on the HELP-4-HEP HCV phoneline, (877) 435-7443; go to help4hep.org.

MAKING SAFER DRUG CONSUMPTION SPACES A REALITY

The work of countless advocates and researchers has resulted in a number of positive outcomes. Across the U.S., cities like San Francisco, Baltimore, Seattle, Denver, and New York City have, at minimum, explored the role of SCS with task forces, community education events, and outreach to local politicians.

In February 2016, Ithaca, New York mayor Svante Myrick announced "The Ithaca Plan: A Public Health and Safety Approach to Drugs and Drug Policy," which included the opening of SCS as an important component of their response to the local opioid crisis.

Similarly, PWUD and other advocates from Seattle and King County formed the "Yes to SCS" coalition, a diverse group of local concerned citizens to push the SCS agenda in their city and county. From there, a task force was formed and their "Heroin and Prescription Opiate Addiction Task Force: Final Report and Recommendations" called for the opening of at least two SCS (called "Community Health Engagement Locations" or "CHELS") in their community.

San Francisco, under the leadership of London Breed of the Board of Supervisors and Laura Thomas of the Drug Policy Alliance, has formed a Safe Injection Facility Task Force to explore the utility of SCS and make recommendations accordingly.

States like California and Maryland have introduced bills to make SCS legal to operate. California has seen particular success with AB 186, a bill sponsored by Susan Talamantes Eggman (D-Stockton) that would allow for pilot SCS programs to operate in up to eight local jurisdictions. This bill marks the first time that SCS legislation was passed. To date, it has passed through the State Assembly, as well as several health and public safety committees. It is awaiting a vote in the state Senate, then back to the Assembly to vote on amendments and finally to be signed by the Governor. Once legal, cities and towns can legally and safely operate SCS with legal protections for both program staff and participants.

—ANDREW REYNOLDS

SELF-ACCEPTANCE
IN THE FACE OF ADDICTION AND HIV

One man's quest to battle stigma and shame

BY JASON ARSENAULT

PHOTOS COURTESY OF JASON ARSENAULT

Hi. My name is Jason, and I'm an alcoholic and an addict.

It took me a long time to be able to admit that. It took me even longer to say it clearly, boldly, and without shame.

So, how did I get to a place where I could pen an article baring my soul in the opening line?

The beginning of my addiction

BEING A GAY TEEN in small-town New Jersey in the 90s wasn't easy. I was bullied by my classmates. I felt isolated and yearned for more friends. I wanted badly to belong. Most of all, I just wanted to be "normal." I was uncomfortable with my identity as a gay man, and felt there was no one else like me, or who understood. Nobody in school or in my community seemed to accept me; why should I?

These feelings of insecurity and loneliness catalyzed a lifelong struggle with depression and anxiety. When I was 16, I discovered that drugs and alcohol brought me temporary relief from my emotional pain. Everything terrible I was facing was distorted into an easy, fuzzy, warm state. I wasn't thinking about my social isolation or the way people treated me when I was drunk. I didn't know it then, but I eventually learned that people in the LGBTQ community are more likely to suffer drug and alcohol addictions than the general population.

The road to rock bottom

I MOVED TO New York City in 1998, and there I found a community of people like me. I began a career in high fashion and found that my being gay wasn't something strange or different—rather, it was embraced. Still, the depression that had emerged when I was a teen persisted, and it would come out and rear its head seemingly whenever it pleased. What's more, I had hardly ceased to drink or use drugs in the years between high school and my career, and in the fast-paced and heavy-partying New York fashion scene there was no shortage of opportunities to

use drugs and alcohol. I had never coped with my adolescent trauma or worked on accepting my true self; I had just piled on layers of numbness with alcohol and other drugs.

My addiction and mental health took a turn for the worse when I was diagnosed with HIV in 2000. I felt anger, resentment, and fear of what would happen next. It felt like a death sentence. I felt unworthy of being accepted in society—on a new level of low than I had ever experienced in my past. My self-medicating grew worse.

At some point, I started using crystal meth, which can unfortunately be quite common among gay men. Crystal meth produces feelings of confidence, power, and happiness with one's self and surroundings. It can also mute feelings of shame and guilt. I'm sure you can understand why, as an HIV-positive gay man who had struggled for much of his adult life with depression and self-acceptance, this drug would have such power over me. I saw crystal meth kill people close to me—but that didn't change my ways.

Some years were good; some years were bad. I tried to get sober on my own, but it wouldn't stick. Each time I relapsed and started drinking or using drugs again, the consequences mounted. I eventually stopped showing up for work, ceased my socializing with friends and family, and failed to fulfill my normal adult responsibilities.

In 2014, I hit rock bottom—or as some in the recovery community call it, the "gift of desperation." I was about to lose my job, a friend had recently passed away from an AIDS-related condition, and I was plagued with depression and a sense of isolation. I had no connection to myself, no self-love; I honestly didn't even know who I was anymore. I realized I was slowly trying to kill myself through my drug abuse, and that if I didn't make a change soon, I would die.

The gift of desperation

PART OF MY TIPPING POINT to change was my willingness to finally admit that I had an issue. Despite my life crumbling around me, it took a massive amount of energy and motivation to make the decision to no longer live the way I'd been living. I checked myself into rehab in the summer of 2014.

The first few days I was in treatment were terrifying. I started out in a five-day detox, during which I faced a range of intense and confusing emotions. I repeatedly questioned if I really needed to be there. I also couldn't do much of anything but sleep at first—my body so exhausted from years of abuse and now detox. But eventually, I started to feel better physically. And once that happened, I could embrace the counseling and wellness activities that ultimately helped me get sober.

Thirty-three days later, my new life began.

The past helps shape the future

ONE OF THE primary reasons people don't seek the help they need for alcoholism or drug addiction is that there's still enormous stigma attached to addiction. Personally, that's why I didn't access treatment for many years when I should have: I didn't want to be labeled an addict. HIV/AIDS is also still shrouded in stigma. The convergence of these two diseases caused me a lot of trauma and paralyzing shame for many years. I believe that I am sober today because I've made peace with my HIV status. Through rehabilitation and continued therapy, I've realized that I could live with these two chronic diseases; I've realized that I have many reasons to wake up every morning and live my life.

I never imagined that my recovery would, in addition to giving me a renewed sense of hope, also end up shaping my career. For the last year and a half, I've worked as a Recovery Coach at the treatment center that saved my life, through which I help individuals maintain their sobriety and healthy lifestyle choices after they leave rehabilitation. After so many years being on the other side of the table, it's amazing that I'm able to use my experience to help others who are seeking guidance and support for their addiction recovery. This role has given me a higher purpose—which is something I didn't have before I got sober.

'AFTER SO MANY YEARS BEING ON THE OTHER SIDE OF THE TABLE, IT'S AMAZING THAT I'M ABLE TO USE MY EXPERIENCE TO HELP OTHERS'

It's also given me the courage to share my story more widely. Over the past three years that I've been sober I've realized that my past isn't anything to be ashamed of. It is simply part of who I am, and it's contributed to the person that I am today—and to my future. Through embracing my past, my addiction and my HIV-positive status, through examining these issues without judgement, through just talking to others about what I've been through and how I arrived at where I am today, I hope that I can help chip away at the still-persisting stigma attached to addiction and HIV. I hope that I can help others realize that we're all human, and we all face down our demons at some point or another. Most importantly, I hope that this story inspires someone out there who is struggling to get the help that they need. PA

JASON ARSENAULT is a Certified Addiction Recovery Counselor and Senior Manager, Recovery Coaching and Community Relations, at Mountainside Treatment Center, in Canaan, Connecticut, which involves connecting Mountainside alumni with resources to help them maintain the healthy lifestyle changes they have learned in treatment. Arsenault has also assisted Mountainside with the development of programming specific to LGBTQ clients. This story was previously published online at The Good Men Project.

TOWARDS AN HIV CURE

BY **JEFF BERRY**

EARTH NEEDS 'POZMONAUTS'
Michael Louella, of the University of Washington AIDS Clinical Trial Unit, says a special group of people is needed to take part in cure studies.

PHOTO ©MARCUS ROSE/IAS

I arrived in Paris just prior to the conference so I could attend the two-day HIV Cure and Cancer Forum, which is sponsored by the International AIDS Society's Towards an HIV Cure initiative. At the World AIDS conference in Durban last year there was a lot of discussion at the Cure meeting about the need for the two fields of oncology and HIV to share their knowledge with one another, as the two areas have a lot of overlap. While cancers and HIV are very different at a molecular level, similar cure strategies are being developed.

About 250 researchers, industry, and community advocates gathered together at the Institut Curie, with about one-third of the attendees from the field of oncology. Genevieve Martin presented on CD32a, a recently identified marker of the CD4 T-cell reservoir. Identifying targets in the reservoir will be key in moving HIV cure research forward, because when HIV infects cells, a very small amount of HIV gets integrated into the cell and gets turned into provirus. This provirus is always lurking, hidden in the cell, even when someone is on suppressive antiretroviral therapy and has undetectable levels of virus in the blood.

One of the highlights of the IAS HIV Cure and Cancer Forum was the panel on clinical trial design and participation. Michael Louella, from the University of Washington AIDS Clinical Trial Unit in Seattle, Washington, explained how we are going to need a very special subgroup of people he termed "Pozmonauts" to participate in cure studies. People participate in cure studies for different reasons, ranging from altruism to the hope that they might receive some clinical benefit from the study. A recent survey found that the number one concern of people who might consider participating in a cure study is the risk of passing on HIV to their partner, as participants will eventually have to go off of antiretroviral therapy to test any cure strategy to see if it actually works. A good amount of education will be needed both for the community as well as for providers, who may be skeptical of cure research and the risks, real or imagined, involved.

In other big cure news, it was reported that a nine-year-old South African child who was diagnosed with HIV infection at one month of age and received antiretroviral treatment during infancy has suppressed the virus without anti-HIV drugs for eight and a half years. This case appears to be the third reported instance of sustained HIV remission in a child after early, limited anti-HIV treatment. It should be noted that at least one percent of people with HIV are elite controllers, who control the virus on their own without medication, so more study and follow up will be needed, but it is indeed encouraging news and will help inform the field of HIV cure research going forward.

CONFERENCE NOTES BY ENID VÁZQUEZ

Following is a roundup of treatment and prevention news announced at IAS 2017. The references appearing in parentheses in each item pertain to the original conference reports. Go to ias2017.org for details.

Bictegravir found non-inferior to Tivicay

The experimental drug bictegravir (BIC) was found to be non-inferior to dolutegravir (DTG, brand name Tivicay, found in Triumeq).

Both HIV medications are from the drug class called integrase strand transfer inhibitors, or INSTIs. Of note, all the INSTIs currently on the market are recommended for first-time use in HIV therapy.

Results are from 48-week data from two Phase 3 clinical trials, Studies 1489 and 1490. BIC was given as a single-tablet regimen (STR), with two other medications in it (emtricitabine and tenofovir alafenamide, or FTC/TAF). DTG was given with FTC/TAF in one study and as the Triumeq single-tablet regimen in the other (the two other drugs in it are lamivudine and abacavir, or 3TC/ABC). (MOAB01 and TUPDB02)

Bictegravir is being developed by Gilead Sciences, while Tivicay and Triumeq are from ViiV Healthcare. FDA approval for a BIC single-tablet regimen is anticipated for next year.

Single-tablet regimen with Prezista

There are several STRs on the market for HIV, but none contain a protease inhibitor (PI) medication, the drug class that started it all for conquering the virus.

That's changing with continuing good results of research with an STR with darunavir (brand name Prezista), the last PI standing among recommended drugs for first-time therapy under U.S. HIV treatment guidelines.

The EMERALD study looked at switching patients from a Prezista-based HIV combination to a Prezista-based STR. At 24 weeks, the 763 patients switched to the Prezista STR in development maintained their undetectable viral load. (TUPEB0372)

The Prezista STR combines darunavir with emtricitabine (FTC) and tenofovir alafenamide (TAF) and a booster drug, cobicistat.

Prezista is also available as Prezcobix, where it is combined with cobicistat.

Switching because of lipids

A European study looked to see if switching patients from a PI-based therapy to one with dolutegravir would improve lipids in people who had high cardiovascular risk or were over the age of 50.

For the patients switched to the INSTI, they found a statistically significant improvement in all lipid fractions (total cholesterol, non-HDL cholesterol, triglycerides, LDL cholesterol, and TC/HDL ration) except HDL, the "good" cholesterol.

Of the 415 study patients, 205 were switched to dolutegravir while the rest were kept on their PI regimen. (TUAB0102)

Doravirine, a new non-nuke

An STR combining the investigational drug doravirine with lamivudine and tenofovir DF (3TC/TDF) was found to be non-inferior to Atripla. **Like the efavirenz (brand name Sustiva) found in Atripla, doravirine is a non-nucleoside analog medication.**

The DRIVE-AHEAD study reported Phase 3 results from 48 weeks. There were statistically significantly fewer neuropsychiatric events and a favorable lipid profile with the doravirine STR. Half of the 728 participants received the doravirine STR and the other half received Atripla. (TUAB0104LB)

LATTE-2: long-acting injectable HIV therapy

You gotta love a latte. What about the results of LATTE-2?

The "LATTE" in this study stands for Long-Acting Antiretroviral Treatment Enabling. **Two HIV drugs were combined into one injectable**, injected either every four weeks or every eight weeks.

Individuals started during a 20-week induction period on a once daily oral combination of an integrase inhibitor (cabotegravir) plus Epzicom (a combination of abacavir and lamivudine, or ABC/3TC).

For years there's been good results reported from this study. Now there's two-year data. At 96 weeks, 94% of the patients on the 8-week injection had undetectable viral load vs. 87% of those on the 4-week injection (and 84% of the people continued on the all-oral regimen of the meds). Still, the clinical trial is going ahead with studying an injection taken every four weeks.

Participants were switched to the injectable from their all-oral HIV therapy, with all of them having undetectable viral load before the switch. LATTE-2 was looking at the injectable, therefore, as a maintenance treatment.

The two drugs in the injectable are the investigational cabotegravir and the already FDA-approved (in oral form) rilpivirine (brand name Edurant, found in Complera and Odefsey). (MOAX0205LB)

Long-acting PrEP with cabotegravir

An injectable form of the experimental drug cabotegravir was reported to be "well tolerated" by HIV-negative people. The HPTN 077 research abstract concluded that the results support going ahead with study of **a 600 mg intramuscular dose every eight weeks for the use of PrEP** (pre-exposure prophylaxis, or prevention of HIV).

The injections followed an induction period of four weeks with daily doses of an oral formulation of cabotegravir. A total of 199 participants received a 600 mg cabotegravir injection, an 800 mg shot, or placebo. Three out of four participants received all of the injections called for in the study, out to 29 or 33 weeks (depending on the dose they were given). Injection site pain and injection site reactions were more common in the active drug doses compared to placebo. These are still early Phase 2 results. (TUAC0106LB)

Long-acting PrEP with rilpivirine

An injectable form of rilpivirine has been studied for PrEP over the years. The HIV Prevention Trials Network (HPTN) took a look at the acceptability of this injectable for PrEP among women here in the U.S. and in Africa.

HPTN 076 reported that, "Continuing high HIV incidence rates coupled with low

adherence to HIV prevention agents (daily oral and topical) in **clinical trials among African women underscore the need for more acceptable and easier to use HIV prevention**. Strong global demand for injectable contraception suggests that new, long-acting, injectable HIV pre-exposure prophylaxis (PrEP) formulations could meet this need."

The 100 African women and 36 U.S. women received bimonthly injections for 28 weeks.

"Most aspects of the injectable were highly acceptable," the research team reported, "although about two-thirds of participants experienced some injection site pain. Most recommendations for improving acceptability were related to reducing injection pain." (**WEPEC0956**)

Daily vs. on demand PrEP

Dutch researchers used data from the Amsterdam PrEP (AmPrEP) demonstration study to look at daily or event-driven use (also called "on demand").

Of 376 men who have sex with men (MSM) in the study, 273 chose daily use of the HIV prevention pill, while 103 chose event-driven use.

A great many reasons were listed for picking daily (dPrEP) or event-driven (edPrEP) use, or later switching.

"Among the reasons to use dPrEP were the convenience of daily routine (n=133), perceived higher dPrEP efficacy (n=34), and fear of side-effects relating to edPrEP re-initiation (n=5). Perceived toxicity and burden of daily medication were reasons to choose edPrEP (n=38). Infection risk was also considered: dPrEP was preferred for unplanned and/or frequent sexual risk behavior (n=79), while edPrEP was chosen when risk was more predictable (n=57)," were among the findings reported by the researchers.

In their conclusion, they wrote, "A great variety of **personal and contextual factors determine the choice for PrEP regimens**, related switches and stops. In order to successfully support future PrEP users, a tailored approach, addressing choices for PrEP regimens as a continuum of flexible and changeable choices, is essential." (**WEAC0106LB**)

Prevention vaccine

Janssen Pharmaceutical Companies of Johnson & Johnson presented "the first look at in-human data for investigation 'mosaic'-based, **prime-boost regimens that are designed to elicit an immune response against a variety of HIV subtypes prevalent worldwide**."

According to a press release from the NIH, which funded pre-clinical development, "Further research will be needed because the ability to elicit anti-HIV immune responses does not necessarily indicate that a candidate vaccine regimen can prevent HIV acquisition." NIH reported that should a larger study move forward, it could begin enrolling late this year or early 2018. As with this part of the study, the APPROACH vaccine research will take place with South African women. Further results from another study, TRAVERSE, are awaited to make a decision about moving forward, NIH reported. (See the session "Progress in Antibody-Mediated Preventive Vaccine Strategies.")

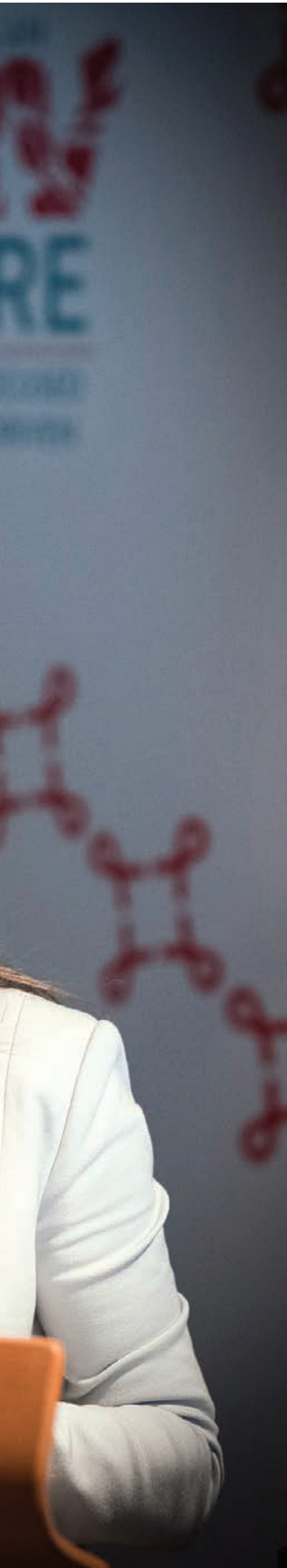

PHOTO ©MARCUS ROSE/IAS

Seven years ago we spoke with HIV cure researcher Sharon Lewin at AIDS 2010 in Vienna. We caught up with her again at this year's conference in Paris; below is a shortened version of our discussion. For a complete transcript, as well as the original 2010 interview, go to positivelyaware.com.

Could you summarize some of the biggest changes from seven years ago, where we are now, and where we're headed?

Seven years later, I think we're much more realistic about how hard this is going to be.

In 2010 it was 12 months after the Berlin patient was first reported, the initial studies on latency reversal were just coming out, and there was this optimism that we were going to be able to do this quite quickly. I think in the last seven years there have been a lot of things that haven't worked. For example, repeat attempts at eradication through transplantation [which was successful for the Berlin Patient, Timothy Brown] have not worked either.

On the positive side, over the last seven years there have been a lot of case reports of post-treatment control, such as the Boston patients, the Mississippi baby, that have really shifted the goals of what we're trying to achieve, to post-treatment control rather than cure.

Immune control is still going to be a part of it, and gene therapy; latency reversal and latency reversing agents are not going to eliminate HIV alone. We have a much better sense of where the reservoir is, and the role of tissue, that's been a big change; also how complex viral persistence is—it's not just latency and low-level proliferation, there's virus in different T-cell subsets.

The other big change is that this is a big part of our next scientific challenge—back in 2010 there were very few people working on cure research, and it's really exploded in the last seven years.

Seven years ago you said you thought that cancer would be much more challenging. Do you still feel that way?

Well, that's interesting. Cancer's not one disease. It's very complex. There are some cancers that you can cure, there are some that can be put into remission, and there are some that you don't have a hope for doing anything. Actually what's changed in that period is there are more cancers you can cure now through immunotherapy or transplantation, so that field has changed dramatically. Immunotherapy, whether it's anti-PD1, or CAR T-cells [engineering immune cells to treat cancer], or interferon, that field has exploded in cancer—the goal of the Cancer and Cure Forum is to see if we can translate those to HIV.

Could you give a brief synopsis of the case report presented by Timothy Heinrich at this conference of the man started on PrEP during early infection?

This is a good example of why just reducing virus to tiny levels can prolong time to rebound, but rebound happens. That was quite a sobering case. This was a man who presented in San Francisco on PrEP. At baseline he was already infected; he started PrEP and in about three days his RNA test came back and he was actually infected. His peak RNA was about 200 copies. It may have been lower on that third day, so they brought him back, rechecked him again, and put him on full antiretroviral therapy. He immediately became undetectable, and they followed him out for three years and checked for virus by undergoing leukopheresis, lymph node and rectal biopsies, and couldn't find any sign of virus. He was undetectable and decided he would have a treatment interruption, and he effectively remained undetectable for about 10 months, when his virus rebounded. So he had un-measurable virus for a prolonged period of time on ART, about three years, a peak viral load of about 200 [copies], an unmeasurable virus in the reservoir, and then rebounded after about 10 months, so a little bit analogous to the Mississippi baby or the Boston patients. He had no immune response to HIV, he always had an indeterminate Western Blot, and then by six months he was non-reactive—he never developed an antibody response.

That's probably for me one of the main findings of the conference, again reinforcing that early treatment of the virus reduces the reservoir but people rebound. That post-treatment control is probably a bit more common than we first thought, with people treated during early infection, depending on how you define post-treatment control. We had the Visconti patients but the definite denominator, it's not clear how common it is. In Fauci's study he did a placebo-controlled vaccine intervention study on people treated in acute infection and then they had a treatment interruption, and two of the people who had placebo had prolonged treatment control, up to two years now. So early treatment reduces the reservoir, it doesn't eliminate it, and if you have maybe 10 percent of people that can stop treatment and have low-level viremia, maybe there is that sweet spot where you have to introduce treatment.

FOR MORE HIV CURE NEWS from IAS 2017 go to Richard Jeffery's TAG HIV Basic Science, Vaccines, and Cure Project Blog at tagbasicscienceproject.typepad.com/tags_basic_science_vaccin/post-treatment-controllers.

END AIDS COALITION

TOP: JAKE GLASER. **MIDDLE:** UNAIDS EXECUTIVE DIRECTOR MICHEL SIDIBÉ AND DESIGNER/AMFAR CHAIRMAN KENNETH COLE. **BOTTOM:** JAKE GLASER, EAC CEO TOM LA SALVIA, AND PA EDITOR JEFF BERRY.

A coalition designed to focus the global AIDS response by fostering collaboration between partners launched during a special event at IAS 2017 in Paris. The End AIDS Coalition was founded by American fashion designer, amfAR Chairman of the board and UNAIDS International Goodwill Ambassador Kenneth Cole. EAC is "a collaboration of leading AIDS experts, scientists, clinicians, policy-makers, faith leaders, businesses, activists, and humanitarians working together to end the AIDS epidemic by 2030."

End AIDS Coalition CEO Tom La Salvia said in an interview with POSITIVELY AWARE that EAC has several areas of focus. "One is to change the narrative to end the epidemic by 2030. We have the tools, but we don't have the political will and the mobilization to do it. The other thing is the global response is not united around the goal of ending the epidemic by 2030. So what we want to do is use all of the incredible work that's being done in the lanes of prevention, treatment, and vaccine research innovation leading to a cure to figure out how the coalition can build bridges across those lanes of activity, so we can all start working together with the common goal. Because if you just stay in your lane and you're just talking prevention, or just talking treatment, or vaccines, you're not going to get there. You really need that to be a concerted effort."

The program featured a number of notable speakers including Michel Sidibé, Executive Director of the United Nations Programme on HIV/AIDS (UNAIDS); Dr. Marijke Winjnroks, Interim Executive Director for the Global Fund to Fight AIDS, Tuberculosis and Malaria; Ambassador Deborah Birx, Unites States Global AIDS Coordinator; and Jake Glaser, the founder of Modern Advocate, a social enterprise connecting like-minded brands and non-profits "to create progress on the most important causes of our time." Jake is the son of Elizabeth Glaser, who founded the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) in 1988.

Jake, who lost his mother and his sister Ariel to the epidemic and was born HIV-positive 32 years ago, gave a moving and powerful speech to close the panel discussion. In it he described how "in my personal life I've strived to find my own personal experience, and to find a fulfilling and meaningful path that resonates with myself and my generation. Because of that I founded Modern Advocate. At Modern Advocate we set out to empower generations about issues like HIV and AIDS, and beyond." Jake said that to end AIDS by 2030, we have to be revolutionary and disruptive, as well as innovative.

"My name is Jake Glaser and I'm HIV-positive," Jake declared at the end of his talk. "I'm proud of the life that I live and of what my mother endured, and I'm proud of the platform that HIV has given me. It has pushed me to become a connector, a communicator, a disruptor, and an activator. My HIV is no longer a crutch; it is a driver. It has shown me the value of life, what it means to live every moment to the max, and what it means to live a life of true value and positivity.

"While my perspective is one of many who are coming together through the End AIDS Coalition, to carry on the work of those who came before us such as my mother and many others, we are using the power of collaboration to end this epidemic once and for all.

"So I leave you with this: the ball's in our court. Every single person in this room, everyone who's joined me on this panel, me included and my entire generation, and the generations to follow. We have an opportunity to make the right decisions, to ask new questions, and to venture into the unknown. And we have the minds and dedication to get there. So I hope you all feel this right now. Because it's now or never."

LEARN MORE ABOUT THE END AIDS COALITION; GO TO endaidscoalition.org.

GLASER: JEFF BERRY • SIDIBÉ AND COLE: ©IAS/STEVE FORREST-WORKERS' PHOTOS

TREE OF LIFE. **"What would an HIV cure mean to you?"** That's the question Karine Dube, David Evans, Richard Jeffreys, Michael Louella, Laurie Sylla, and Jeff Taylor asked their fellow attendees at last year's International AIDS Conference in Durban, South Africa. Respondents wrote their answers on leaf-shaped pieces of paper. Afterward, members of the Seattle-based defeatHIV community advisory board sorted the paper "leaves" into themes. A word cloud was created from the 244 responses, and the words morphed into a tree. The word tree was unveiled in a presentation at IAS 2017. "That it captures the most common themes while preserving all the voices that answered our question was a great source of interest at IAS, especially for those living with HIV," said Michael Louella.

ILLUSTRATION: MICHAEL LOUELLA

OUR STORY IS YOUR STORY

Honoring 30 years with the personal stories of lives touched by TPAN

BY GARY NELSON

A few months ago, PA's associate editor Enid Vázquez shared some recollections from her 20-plus years of working at TPAN (*TPAN: 30 Years of Empowerment*, July+August 2017). "People often say, 'TPAN saved my life.' I know that sometimes that is literal, and sometimes that is an emotional response. The emotional perception is just as valid." We at TPAN are always moved when we hear personal victories that are achieved through our grassroots organization, or these pages of our national magazine. As we celebrate TPAN's 30th anniversary throughout the year, we're commemorating three decades with personal stories and remembrances—and invite you to share your own.

Our longtime readers know the story of Chris Clason and TPAN's founding. After testing positive for HIV, Chris Clason was told he was "too healthy" to receive services from local organizations—he could pay to take part in a therapeutic support group once he had developed AIDS. Instead, Clason ran a newspaper ad for HIV-positive Chicagoans to join together in sharing information and support. He envisioned a collection of people more than an organization; a meeting that would be inclusive, free, and "provide information, but to support fellowship too."

Participation and mutual support were central to Chris's vision for the early meetings. "I wanted to hear about peoples' problems and hardships but with the idea that the sharing could lead to an answer or solution; someone else may have successfully handled that problem and could share their experience."

A group of 16 met in Clason's living room in June of 1987 for the first meeting. They shared news clippings, announcements of drug trials, and personal stories of the emotional and physical hardship of living with the new virus. Together, they found their own answers on how to manage HIV—and more importantly, fostered hope for those living with HIV, and honoring those lost to the epidemic.

The group grew thanks to Chris and early members' attention to inclusion. In a newsletter sent four months after the first meeting, Chris wrote, "If there is one thing I have discovered within the circle of familiar and new faces that gather each week… it is that rather than limiting ourselves to the perimeter of the circle, each meeting at TPA [as it was known then] is a further expansion of self, of discovery and of healing. There is ROOM here. Room to learn, room to share, room to grow. TPA will grow. I hope that you will be a part of the growing process."

Participants found the promised room in early meetings and support from one another. But TPAN is, and has always been, bigger than Chris. "TPA exists as it does today, not because of one or two people, but because of all of us working together," wrote Chris prior to his death in 1991. Many hands provided comfort for early members—in some instances literally.

Mary Pat Brown, a TPAN volunteer, met Chris when he dropped off TPA resources at her office. She described their meeting as an "immediate connection. His positive spirit was both engaging and unbelievable to me." Mary Pat began attending meetings and was moved by the resilience of early members. "I cried twice a week at those meetings, I was completely, completely overwhelmed with sadness regarding the inevitable fate of all those present. How could this very large group of men facing the most dismal of health diagnoses be cheerful? So happy, resourceful, laughing? Funny, even?"

Mary Pat, Hannah Hedrick, and Lisa Congelton were fondly known as the "TPA Angels" for their selfless care provided to meeting participants. Hannah, a director of medical education, research, and information at the American Medical Association, shared her time, leading weekly yoga and T'ai Chi classes, and teaching holistic health workshops.

TPAN WAS ORIGINALLY KNOWN AS 'TPA NETWORK'

Writing in 1993, Hannah shared that TPA continued its grassroots appeal. "People come to classes at TPA hoping to get help. But what turns out to have the most meaning is *giving* help." In addition to alternative therapies, Hannah, Lisa, and Mary Pat would provide massages at each meeting. "It became our trademark," shared Mary Pat. "I was eager to be a part of something meaningful to support the group. And it stopped my tears—for the most part. But I was still emotional as I felt I was walking on sacred ground, privileged to be among the ever-growing TPA membership. It was all we three could do to be sure all in attendance received a massage."

These acts of incredible love and perseverance, and the selflessness of TPAN's founders and volunteers, is what I think of when I hear that "TPAN saved a life." TPAN was founded by our members, and continues to be sustained by each client taking part in our groups, our readers' contributions, and our community's energy and resiliency. Our story is your story. PA

SUBMIT YOUR STORY

Go to tpan.com/yourstories to post online, post on social media with #ourstoryisyours, or leave a voice message at (773) 598-9435. We will continue to share your stories through the end of the year. These stories, and many more, will be shared in person at TPAN's 30th anniversary celebration in September.

All current and former clients, supporters, and health advocates are invited to celebrate 30 years of TPAN on September 28, from 7–10 p.m. at Moonlight Studios in Chicago. Go to tpan.com/tickets to learn more and purchase tickets.

PHOTOS: TPAN ARCHIVES

TEST POSITIVE
NETWORK

AWARE

Hope

REPRIEVE

There's a Link Between HIV & Heart Disease.

- Studies have shown that people living with HIV are 50–100% more likely to develop cardiovascular disease (including heart attack and stroke) than individuals without HIV.
- REPRIEVE is a clinical research trial exploring long-term prevention of heart disease among people living with HIV.

Preventing Heart Disease

REPRIEVE will evaluate if a daily dose of pitavastatin lowers the risk of heart-related disease among people living with HIV.

Pitavastatin, is a statin that is approved by the FDA. Statins are used to lower cholesterol and prevent heart disease.

Based on current information, pitavastatin is considered safe for use with all MD-prescribed antiretroviral therapy regimens.

Benefits of REPRIEVE to Minimize Risk

All participants will receive guidance on steps to improve heart health, including:

Taking antiretroviral therapy

Keeping cholesterol, blood pressure, and blood sugar in good range

Not smoking

Eating well

Exercising

But long term research is needed for HIV-specific strategies for preventing heart attack and stroke.

Learning More About Heart Disease Prevention Among People with HIV

WHAT YOU NEED TO KNOW ABOUT REPRIEVE

LENGTH OF PARTICIPATION
48 months on average

SIMPLE TIME COMMITMENT
Visits about **3** times per year

THERE'S A SITE NEAR YOU

YOU MAY BE ELIGIBLE IF YOU ARE:

- ☑ HIV positive between the ages of 40 and 75
- ☑ On antiretroviral therapy (ART) for at least 6 months prior to study entry
- ☑ No history of cardiovascular disease (including heart attack or stroke)
- ☑ Not currently using a statin drug

Learn more about the REPRIEVE trial and how to sign-up: www.reprievetrial.org

Participating in the REPRIEVE trial is not about "adding just another pill", it's about paving the way to healthier hearts for the HIV community.

Help the community learn about the REPRIEVE clinical trial:

Call: 1-877-29-HEART

facebook.com/reprievetrial

@reprievetrial

The REPRIEVE Trial is primarily funded by the NIH Heart Lung and Blood Institute (NHLBI) and supported by the NIH Division of AIDS (DAIDS), utilizing the ACTG and other trial networks.

'GO-TO' AGENCIES

WHEN YOU NEED INFORMATION, SERVICES, AND OTHER RESOURCES

This list is by no means complete. There are many more HIV/AIDS organizations offering programs and services than can fit here, but the following are "go-to" agencies, most of which are non-profit AIDS service organizations that provide essential services for people living with HIV. For a longer (and searchable) list, go to positivelyaware.com/gotoagencies. To request to be added to the online listing, email r.guasco@tpan.com.

ALABAMA

AIDS Alabama
Birmingham, Mobile
aidsalabama.org
HIV/STI testing, case management, and medical and mental health services, emergency assistance, housing, support groups, utility assistance, and help in enrolling for insurance. Latino/x outreach includes translation and bilingual support services.

ALASKA

Interior AIDS Association
Fairbanks
(907) 452-4222
interioraids.org
casemanager@interioraids.org
Case management, food pantry. Housing assistance program includes aid for rent and utilities. Needle exchange, harm reduction services, and a comprehensive program for people living with HIV who use drugs.

ARIZONA

Southern Arizona AIDS Foundation
Tucson
saaf.org
Case management, support groups, housing assistance. Other services provide complementary therapies (massage, acupuncture), dental care, access to substance abuse treatment, and transportation assistance. Anti-violence program includes crisis intervention and a bilingual hotline: (520) 624-0348.

Southwest Center for HIV/AIDS
Phoenix
(602) 307-5330
swhiz.org
HIV testing, support groups, help with job search, and legal assistance. Positive Connections is a workshop about living with HIV, geared to both newly diagnosed and long-term survivors.

ARKANSAS

Ozarks AIDS Resources and Services
ozarksaids.org
Free clinic for residents of Baxter, Boone, Carroll, Marion, and Newton counties.

CALIFORNIA

APEB (AIDS Project East Bay)
Oakland
(510) 663-7979
apeb.org
Geared primarily toward Black men in Oakland and the East Bay who have sex with men. Ryan White-funded case management. Support groups, education programs, housing, and substance abuse programs, and programs for youth.

APLA Health
(213) 201-1600
aplahealth.org
Originally founded as AIDS Project Los Angeles, offers a wide array of programs and services such as HIV specialty, medical, and dental care. Case management, counseling, housing assistance, and food pantry. PrEP and PEP available. Several locations throughout Los Angeles; satellite facilities in Lancaster and Long Beach.

Being Alive!
Los Angeles
beingalivela.org
Services include mental health counseling, complementary therapies (acupuncture, massage), and yoga.

Desert AIDS Project
Palm Springs
(760) 323-2118
desertaidsproject.org
HIV specialty, comprehensive medical, and dental care offered. Additional services include case management, food vouchers, monthly farmers market. Mental health services, substance abuse counseling, support groups.Transportation services, gas voucher cards, and bus passes. Short-term housing, rent and utility assistance available. On-site pharmacy. Additional Palm Springs location and facility in Indio.

The San Diego Community Center
(619) 692.2077
thecentersd.org/programs/hiv-services
HIV testing, counseling and social groups. HIV health education, Black men who have sex with men, meditation, substance abuse, and youth. Spanish language group. Referrals to local HIV medical services.

San Francisco AIDS Foundation
sfaf.org
Medical case management, counseling, housing assistance, and needle exchange. Substance use services include a walk-in program. PrEP available. Spanish-only programs available. ***Ofrecen servicios en español:*** **(415) 487-8000.**

Tenderloin Health Services
San Francisco
(415) 674-6140
sfccc.org/tenderloin-health-services
The former GLIDE Health Services Clinic offers primary medical care, case management, counseling and mental health, acupuncture, and substance abuse. Chinese, Spanish, Tagalog, and Vietnamese also spoken.

COLORADO

Boulder County AIDS Project
(303) 444-6121
bcap.org
Medical case management, medical referrals, emergency financial assistance, food pantry and nutritional support, and health insurance information.

Colorado AIDS Project
coloradohealthnetwork.org
Six offices in Colorado Springs, Denver, Fort Collins, Grand Junction, Greeley, and Pueblo provide HIV-related health, prevention, and education services such as case management, mental health and substance abuse counseling, housing assistance, transportation, nutrition services, and financial assistance.

CONNECTICUT

AIDS Connecticut
Hartford
(860) 247-AIDS
aids-ct.org
Services include housing assistance funding, medical case management, treatment adherence program. The Syringes Services Program offers needle exchange, harm reduction information; Naloxone and overdose response education.

DELAWARE

Delaware AIDS
aidsdelaware.org
Case management, housing and utility assistance, drop-in and support group, food pantry. Referrals for transportation to medical and social service appointments. Locations in Wilimington and Rehoboth Beach; services available in New Castle, Kent, and Sussex counties. A list of area HIV specialists and clinics available online.

CONTINUES >>

DISTRICT OF COLUMBIA

Whitman-Walker Health
(202) 745-7000
whitman-walker.org
Comprehensive medical and urgent care, dental, and mental health service. Case management, legal assistance, and youth services. Transgender care in a respectful environment. PrEP and PEP information. On-site pharmacy. Four locations in D.C. ***Ofrecen servicios en enspañol.***

FLORIDA

Broward House
browardhouse.org
Initially founded to provide housing and compassionate care, Broward House services now include case management, mental health services, and substance abuse treatment; assisted living and transitional residential programs.

The McGregor Clinic
3487 Broadway, Fort Myers
(239) 334-9555
mcgregorclinic.org
HIV testing and counseling, primary HIV medical care, Ryan White-funded case management, food pantry, and clothes closet. Services also offered in Spanish and Haitian Creole.

Okaloosa AIDS Support & Informational Services (OASIS)
aidsoasis.org
Founded in 1991 by David Neil, who died soon afterward, OASIS provides case management, advocacy training, and a food pantry.

GEORGIA

AID Atlanta
aidatlanta.org
Founded in 1982, the agency boasts a broad range of services and has become the most comprehensive AIDS service organization in the Southeast. Services include medical case management, medication assistance, housing services, and behavioral health. PrEP available. On-site pharmacy.

ILLINOIS

AIDS Foundation of Chicago
(312) 922-2322
aidschicago.org
AFC connects people living with HIV to medical case management and counseling services.

Howard Brown Health
Chicago
howardbrownhealth.org
Founded in 1974 to serve the GLBTQ community, there are now several locations throughout Chicago. Primary and HIV specialty care and health services for men, women, transgender, and gender non-conforming. Mental health, substance use and abuse counseling, aging services, and support groups. PrEP and PEP available. Operates the Broadway Youth Center.

The Project of the Quad Cities
Moline
(309) 762.5433
tpqc.org
Testing, counseling, case management, and weekly support groups offered. Viral for Your Survival youth program offers a weekly drop-in center. Additional locations in the QC area.

TPAN
Chicago
(773) 989-9400
tpan.com
Founded in 1987, TPAN provides case management, support groups, and counseling services. Primary medical care offered on-site through Howard Brown Health. TPAN is also the publisher of POSITIVELY AWARE magazine.

INDIANA

Clark County Health Department / Hoosier Hills AIDS Coalition
Jeffersonville
(812) 288-2706
clarkhealth.net/std.htm
Testing and counseling, STI clinic, substance abuse counseling. Some emergency assistance for food, rent, and utilities. Serves Clark, Floyd, and nine other counties in southeastern Indiana.

Damien Center
damiencenter.org
Indianapolis on-site HIV medical care, case management, and mental health services; counseling and substance abuse. Food pantry, short-term financial assistance for rent and utilities, and legal services.

KANSAS

Positive Connections
Topeka
pcneks.org/resources
Resources page links to community-based organizations and regional public health departments that provide primary medical care, case management, and mental health services.

KENTUCKY

Kentuckiana AIDS Alliance
Louisville
kyaids.org/services
A consortium of area HIV organizations and public health departments. Comprehensive HIV medical provided through the 550 Clinic, (502) 561-8844, affiliated with the University of Louisville. Mental health, dental care, family services, and legal assistance through other agencies.

LOUISIANA

Acadiana Care
Lafayette
(337) 233-2437
acadianacares.org
Case management, mental health counseling, support groups, transportation assistance to medical care and social services, food bank. Short-term aid for mortgage, rent, utilities, and other critical needs to prevent homelessness.

Belle Reve
batonrougeaidssociety.org
Opening its doors in 1993, Belle Reve became the first non-profit, assisted-living facility in Louisiana for people living with HIV. Support groups and psychosocial support services, and substance abuse issues.

MAINE

Frannie Peabody Center
Portland
(207) 774-6877
peabodycenter.org
Case management; mental health services; substance abuse counseling; and housing assistance in the form of mortgage, rent, and utility payments.

Health Equity Alliance
(207) 990-3626
mainehealthequity.org
The former Down East AIDS Network (which had been founded in 1987) provides Downeast Maine with services such as case management, drug use/harm reduction, and HIV education. In Bangor, with multiple locations.

MARYLAND

Chase Brexton
Baltimore
(410) 837-2050
chasebrexton.org
Case management, medical, dental, and mental health services. Gender-affirming support provided to transgender individuals and to all gender identities. On-site pharmacy. Bilingual and translation services available. Locations in Baltimore and Columbus, Maryland.

MASSACHUSETTS

AIDS Support Group of Cape Cod (The Cape)

(508) 487-9445
asgcc.org
Founded in 1981. Medical case management, substance abuse counseling, needle exchange, and referrals to HIV services. Transportation assistance to medical and social service appointments. Housing programs include assistance with rent, utilities, and home fuel. Locations in Falmouth, Hyannis, and Provincetown.

Fenway Health
Boston
(617) 927.6000
fenwayhealth.org
Founded in 1971 as community-based drop-in center. Primary and HIV specialty medical care, dental, eye, mental health, as well as women's and transgender health. On-site pharmacy. Three locations in Boston.

MICHIGAN

AIDS Partnership Michigan
Detroit
miunified.org
HIV and hepatitis C testing, case management, health insurance navigation, housing assistance, re-entry assistance, overdose prevention, and needle exchange.

Lansing Area AIDS Network
laanonline.org
Case management and other support services.

MINNESOTA

The Aliveness Project
Minneapolis
(612) 824-5433
aliveness.org
Case management; nutrition program offers workshops and individual counseling. Lunch, dinner, and Saturday brunch are served to clients. Free acupuncture, massage and chiropractic care.

MISSOURI

Saint Louis Effort for AIDS
(314) 645-645
stlefa.org
@STLEFA
Case management links clients to primary medical care, medications, and other essential services. Free HIV and STD testing by appointment. Support and social groups. Pets are Wonderful Support (PAWS). Programs target those who've been "lost to care."

MONTANA

Montana Gay Men's Task Force
mtgayhealth.org
Retreats for men who are gay, bisexual, or have sex with men (MSM). In addition, specific retreats for HIV-positive men, young gay men, and Native American gay, bisexual, transgender, and/or two spirited occur each year. The website's resource page lists a number of agencies throughout the state, but try calling first to see that the office is still open and in operation.

NEBRASKA

Nebraska AIDS Project
nap.org/home/programs-and-services
In addition to referrals to medical care, provides case management. Locations in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff, and serves counties in southwest Iowa (through the Omaha office) and counties in southeast Wyoming (Scottsbluff office). To find the nearest location, go to nap.org/home/contact.

NEW JERSEY

Hyacinth AIDS Foundation
(732) 246-0204
hyacinth.org
Case management, mental health and substance abuse counseling. Also offers pastoral care, legal services, and re-entry program for the previously incarcerated. Navigator Support is a "buddy" program that pairs up new clients with someone living with HIV for emotional support.

NEW MEXICO

New Mexico AIDS Services
(505) 938-7100
nmas.net
Provides assistance with food and housing for people living with HIV. Additional services available through UNM Truman Health Services, Southwest CARE, or First Nations.

NEW YORK

Callen-Lorde Community Health Center
New York City
(212) 271-7200
callen-lorde.org
HIV testing, along with PrEP and PEP. Primary care includes services for women, transgender, and youth. Assistance with insurance enrollment. On-site pharmacy. Additional locations
.

GMHC
New York City
gmhc.org
Founded in 1982 as Gay Men's Health Crisis, GMHC provides a wide array of services for people living with HIV. Medical care, dental, mental health serves, case management, substance use counseling and treatment adherence. Legal and financial services. Syringe access program. Buddy Program connects clients (from newly diagnosed to long-term survivors) with Buddy volunteers whose primary function is to provide emotional support. Comprehensive care services for transgender and gender nonconforming individuals.

NORTH CAROLINA

Western North Carolina AIDS Project
Asheville
(800) 346-3731
wncap.org
Case management, help with obtaining HIV medications, emergency financial assistance, transportation coordination to medical appointments. Support group meets first and third Tuesday of the month.

OKLAHOMA

Tulsa Cares
Tulsa
(800) 474-4872
FOOD PANTRY: (918) 834-GRUB (4782)
tulsacares.org
Founded in 1991 as a community response to the growing need for coordinated HIV/AIDS care, services include medical case management, emergency prescription medicine assistance, transportation assistance to medical and social service appointments, and emergency food pantry.

OHIO

Equitas Health (formerly AIDS Resource Center Ohio)
equitashealth.org
Fifteen offices cover 11 cities in Ohio, Kentucky, and West Virginia. Primary and HIV specialty care includes trans and women's health. Other services include dentistry, legal aid, mental health, and a full-service pharmacy.

OREGON

Cascade AIDS Project
Portland
(503) 223-5907
cascadeaids.org
Support groups and assistance with employment, housing, and insurance. Testing and information about PrEP.

The CareLink program helps those who are newly diagnosed, have fallen out of care, or recently released from incarceration get connected to medical care. The Service Center is a one-stop shop for housing and basic needs referrals; walk-ins welcomed. HIV health care navigation for women and youth.

PENNSYLVANIA

Lehigh Valley Health Network
Allentown
(610) 969-2400
lvhn.org/facilities_directions/community_clinics/aids_activities_office
Comprehensive HIV care clinic.

Philadelphia FIGHT Community Health Centers
Philadelphia
(215) 985-4448
fight.org
HIV and hepatitis C clinics, case management, dental care, mental health services, substance abuse, nutritionist. Re-entry assistance .FIGHT's signature program is an adult health literacy program known as Project TEACH.

PUERTO RICO

Migrant Health Center, Western Region
migrantspr.com
Operates clinics throughout Puerto Rico's western region, focusing on care for migrant agricultural workers. Primary care, dental and eye care, mental health services available. Pharmacy on-site. Website in English and Spanish. ***Ofrecen servicios por médico de familia, generalista, pediatra, internista, OB/Gyn, dentista, optómetra, salud mental, farmacia, vacunación y laboratorio.***

RHODE ISLAND

AIDS Project Rhode Island
Providence
aidsprojectri.org
Offers HIV and hepatitis C testing, case management, and mental health counseling.

SOUTH CAROLINA

AID Upstate
aidupstate.org
Provides medical case management, mental health evaluation, assistance with HIV-related medical visits and labs, rent and utility payment assistance, food/nutritional assistance, transportation assistance to HIV-related appointments, substance and alcohol abuse therapy assistance.

Lowcountry AIDS Services
Charleston
(843) 747-2273
aids-services.com
Provides medical case management, support groups, nutritional program, housing assistance, and legal services. On-site MedExpress Pharmacy (844-696-3339). Serves Berkeley, Charleston, and Dorchester counties.

CONTINUES >>

TENNESSEE

Nashville Cares
633 Thompson Lane,
(615) 259-4866
nashvillecares.org
Founded in 1985, services include case management, short-term financial assistance for housing and utilities. Support programs include YBU, for African American men up to age 25; Brothers United, for African American men age 26 and over. Information on PrEP.

TEXAS

AIDS Foundation Houston
aidshelp.org
Founded in 1982 as Texas' first AIDS service organization; case management, mental health, substance abuse treatment, and linkage to medical and social services.

AIDS Services of Austin
(512) 458-2437
asaustin.org
Founded more than 30 years ago, programs include case management, dental care, women's services, food bank. Emergency financial assistance. Legal services through Volunteer Legal Services of Central Texas.

AIDS Services of Dallas
(214) 941-0523
aidsdallas.org
Housing and support services for low income and homeless individuals and families living with HIV/AIDS. Housing and medical case management. Home-delivered meals and volunteer groups provide nutritional and social support. Transportation to medical appointments available.

VIRGINIA

Valley AIDS Network
Harrisonburg
(540) 568-8833
valleyaidsnetwork.org
Serves the Central Shenandoah Valley. Provides HIV testing, medical case management, transportation assistance to medical and social services appointments, housing assistance, and food pantry. ***Ofrecen servicios en español:*** *valleyaidsnetwork.org/servicios.*

WASHINGTON

CHAS Health
Spokane
(509) 444-8200
chas.org/services/medical/hiv-program
Ryan White-funded HIV clinic, referred to as CHIV, serves eastern Washington and North Idaho. Primary medical care includes women's health, pediatrics, and urgent care, as well as dental and mental health services. On-site pharmacy.

End AIDS Washington
endaidswashington.org
This collaboration of community-based organizations, government agencies and educational and research institutions provides information and referrals for HIV testing, treatment, health insurance, and PrEP.

WEST VIRGINIA

Caritas House, Inc.
Morgantown
(304) 985-0021
caritashouse.com
Serves north-central West Virginia primarily by linking to HIV-related medical, mental health, and social services. Food pantry available. Colligo House is a permanent supportive housing project for people who are chronically homeless and have mental illness, substance abuse, or HIV/ AIDS.

WISCONSIN

AIDS Resource Center of Wisconsin
arcw.org
HIV clinic in Wisconsin; dental clinic and pharmacy also on-site. Other services include case management, mental health, food pantry, housing programs, and legal services. PrEP at the Milwaukee, Madison, Green Bay and Kenosha locations.

FOR YOURSELF, FOR YOUR AGENCY,

GET **POSITIVELY AWARE.**

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COMMEMORATING 30 YEARS OF HOPE

THURSDAY, SEPTEMBER 28, 2017

TPAN was founded in 1987 as Chicago's grassroots response to the AIDS epidemic. **On Thursday, September 28, TPAN's founding members will be honored** in an evening commemorating the work of the organization they started.

Join guest speaker Peter Staley, an early member of ACT UP, also founded in 1987, as we celebrate TPAN's 30th anniversary.

THURSDAY, SEPTEMBER 28, 2017

MOONLIGHT STUDIOS 1446 W. KINZIE STREET, CHICAGO

VIP $175 • GENERAL ADMISSION $125

tpan.com/tickets

In adults with HIV on ART who have diarrhea not caused by an infection

Tired of planning your life around diarrhea?

Enough is Enough

Get relief. Pure and simple. Ask your doctor about Mytesi.

Mytesi (crofelemer):

- Is the **only** medicine FDA-approved to relieve diarrhea in people with HIV
- **Treats diarrhea differently** by normalizing the flow of water in the GI tract
- Has the same or fewer side effects as placebo in clinical studies
- Comes from a tree sustainably harvested in the Amazon Rainforest

What is Mytesi?

Mytesi is a prescription medicine that helps relieve symptoms of diarrhea not caused by an infection (noninfectious) in adults living with HIV/AIDS on antiretroviral therapy (ART).

Important Safety Information

Mytesi is not approved to treat infectious diarrhea (diarrhea caused by bacteria, a virus, or a parasite). Before starting you on Mytesi, your healthcare provider will first be sure that you do not have infectious diarrhea. Otherwise, there is a risk you would not receive the right medicine and your infection could get worse. In clinical studies, the most common side effects that occurred more often than with placebo were upper respiratory tract (sinus, nose, and throat) infection (5.7%), bronchitis (3.9%), cough (3.5%), flatulence (3.1%), and increased bilirubin (3.1%).

For Copay Savings Card and Patient Assistance, see Mytesi.com

Mytesi®
(crofelemer) 125 mg delayed-release tablets

RELIEF, PURE AND SIMPLE

Please see complete Prescribing Information at Mytesi.com.

NP-390-7

IMPORTANT PATIENT INFORMATION

This is only a summary. See complete Prescribing Information at Mytesi.com or by calling 1-844-722-8256. This does not take the place of talking with your doctor about your medical condition or treatment.

What Is Mytesi?

Mytesi is a prescription medicine used to improve symptoms of noninfectious diarrhea (diarrhea not caused by a bacterial, viral, or parasitic infection) in adults living with HIV/AIDS on ART.

Do Not Take Mytesi if you have diarrhea caused by an infection. Before you start Mytesi, your doctor and you should make sure your diarrhea is not caused by an infection (such as bacteria, virus, or parasite).

Possible Side Effects of Mytesi Include:

- Upper respiratory tract infection (sinus, nose, and throat infection)
- Bronchitis (swelling in the tubes that carry air to and from your lungs)
- Cough
- Flatulence (gas)
- Increased bilirubin (a waste product when red blood cells break down)

For a full list of side effects, please talk to your doctor. Tell your doctor if you have any side effect that bothers you or does not go away.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Should I Take Mytesi If I Am:

Pregnant or Planning to Become Pregnant?

- Studies in animals show that Mytesi could harm an unborn baby or affect the ability to become pregnant
- There are no studies in pregnant women taking Mytesi
- This drug should only be used during pregnancy if clearly needed

A Nursing Mother?

- It is not known whether Mytesi is passed through human breast milk
- If you are nursing, you should tell your doctor before starting Mytesi
- Your doctor will help you to decide whether to stop nursing or to stop taking Mytesi

Under 18 or Over 65 Years of Age?

- Mytesi has not been studied in children under 18 years of age
- Mytesi studies did not include many people over the age of 65. So it is not clear if this age group will respond differently. Talk to your doctor to find out if Mytesi is right for you

What Should I Know About Taking Mytesi With Other Medicines?

If you are taking any prescription or over-the-counter medicine, herbal supplements, or vitamins, tell your doctor before starting Mytesi.

What If I Have More Questions About Mytesi?

For more information, please see the full Prescribing Information at Mytesi.com or speak to your doctor or pharmacist.

To report side effects or make a product complaint or for additional information, call 1-844-722-8256.

Rx Only

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Mytesi comes from the *Croton lechleri* tree harvested in South America.