



POSITIVELY AWARE

MARCH+APRIL 2026

HOW U=U IMPACTS LIVES

10 years of U=U:
Where it's succeeded,
and where it's fallen short

KIM CANADY

'Being born with HIV meant expecting the worse—I chose to live instead.' Read her essay. PLUS: Brandon Cox Sanford (aka Andy Feds), also born with HIV, writes, 'I chose not to let HIV limit how I define me.'

YOUR CHEAT SHEET FOR AGING WITH HIV

CROI 2026 CONFERENCE UPDATE:

A new daily pill for people on complex regimens is coming. Reshaping children's HIV treatment. Opt-out screening success. Global PrEP efforts in the face of U.S. policy upheaval.



Rick Guasco
EDITOR-IN-CHIEF
@rickguasco

Enid Vázquez
ASSOCIATE EDITOR
@enidvazquezpa

Trudy Ring
COPY EDITOR

Greg Mytych
ART DIRECTOR

COLUMNIST
Bridgette Picou

CONTRIBUTING WRITERS
Larry Buhl
Edith Magak

PROOFREADER
Jason Lancaster

PHOTOGRAPHERS
Sean Black
John Gress

SPANISH TRANSLATION
Rosa E. Martínez Colón

BUSINESS MANAGER
Kate Vlahoulis
kate@positivelyaware.com

DISTRIBUTION MANAGER
Denise Crouch
distribution@positivelyaware.com

SUBSCRIBE OR ORDER COPIES
positivelyaware.com/subscribe

LIVE LIFE POSITIVELY AWARE.
SINCE 1990, PUBLISHED BY



5537 N. BROADWAY
CHICAGO, IL 60640-1405
(773) 989-9400
FAX: (833) 696-0778
inbox@positivelyaware.com
positivelyaware.com
@posaware

TPAN was founded in 1987 in Chicago as Test Positive Aware Network, when Chris Clason hosted 16 other individuals living with HIV in his 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.



BE GREEN.
SHARE OR RECYCLE
THIS MAGAZINE.

ONLY ON POSITIVELYAWARE.COM



FIRST PERSON

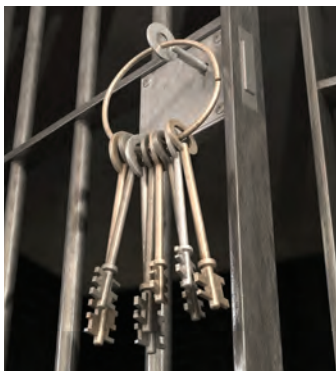
A 'pre-obituary' as protest by a long-term survivor in Florida

Kamaria Laffrey writes an indictment of a system that's failing people living with HIV
BY KAMARIA LAFFREY

When Florida health officials announced sweeping changes to the state's AIDS Drug Assistance Program in January, thousands of people with HIV were left scrambling to understand what the proposed cuts could mean for their care. For Kamaria Laffrey, an advocate, mother and longtime Floridian living with HIV, the uncertainty felt existential. In protest, she's written what she calls a "pre-obituary"—a searing meditation on what happens when access to lifesaving treatment is treated as optional, contingent or too costly. It's an indictment of the system that's failed her and thousands in Floridians living with HIV.

"I wrote this to channel my rage for feeling like the autonomy of how I live my life was being stripped away through an administrative decision," she told POSITIVELY AWARE. "I will not let the stripping away of my humanity be acceptable. I will state who's responsible and hold them accountable to and through my last breath."

positivelyaware.com/pre-obit



HIV Is Not a Crime Day statement ties criminalization laws to immigration

The Center for HIV Law and Policy marks Feb. 27 by examining the intersections of HIV criminalization, immigration enforcement and public health access
BY RICK GUASCO

For National HIV Is Not A Crime Awareness Day, the Center for HIV Law and Policy (CHLP) releases a public statement calling for broader solidarity across movements addressing HIV criminalization, immigration enforcement and policing. Also known as HINAC Day, the annual observance takes place February 27 and highlights the impact of state laws that criminal-

ize people living with HIV.

CHLP's statement, titled "Being Human is Not a Crime: HIV, Immigration, and State Violence," says that HIV criminalization laws continue to expose people to arrest, prosecution, and incarceration based on their health status. The organization argues that these laws can also carry immigration consequences, including detention or deportation, when arrests or convictions are interpreted through immigration proceedings.

positivelyaware.com/hinac-day-2026



FIRST PERSON

Are we building community or just protecting our silos?

Communities remember who shares the mic and who keeps it
BY VON BIGGS

At nearly every HIV or LGBTQ+ community event in Florida's Broward County, the pattern repeats. The same leaders circulate, the same organizations occupy the center and the same photos appear online. Meanwhile, newer nonprofits with deep neighborhood trust and urgent ideas stand at the edges of the room and the edges of funding conversations.

The problem is not a lack of passion or programs. The problem is a quiet and consistent pattern of siloed leadership that keeps our HIV and LGBTQ communities from reaching the people who need us most. When collaboration becomes optional and reciprocity becomes rare, we do not just lose good intentions. We lose reach, relevance and lives that depend on timely care, credible information and culturally grounded support.

positivelyaware.com/first-person-building-community

MARCH+APRIL 2026

POSITIVELY AWARE • VOLUME 36 NUMBER 2 • positivelyaware.com • @posaware



THIS ISSUE

10

10 Years of the U=U campaign: Where it's succeeded—and fallen short

Publicizing that people with fully treated HIV can't transmit it sexually has reduced stigma and even changed criminalization laws—but the concept still faces widespread ignorance and disbelief.

BY TIM MURPHY

16

FIRST PERSON

When Brandon met Jasmine

Born with HIV, newlywed Brandon Cox Sanford (aka Andy Feds) says, 'I choose not to let HIV limit how I define me.'

BY BRANDON COX SANFORD

17

FIRST PERSON

The perfect funeral

'Being born with HIV meant expecting the worst—I choose to live instead.'

BY KIM CANADY

18

Your cheat sheet for aging optimally with HIV

Have you had these conversations or asked for these tests and screens from your provider?

BY TIM MURPHY

28

How antibodies and T cells could keep HIV in check—without ART

No silver bullet, but a complex strategy bolsters the immune system.

BY LARRY BUHL

30

Today's chemsex pandemic requires novel approaches

We must adopt a syndemic response to the complicated relationship between HIV and sexualized drug use.

BY DAVID FAWCETT, PhD, CST, CSAT, LCSW

CROI 2026

20

A new once-daily pill could simplify treatment for people with drug resistance

ARTISTRY study results find bictegravir and lenacapavir single-tablet regimen could simplify treatment for people with HIV on complex regimens.

BY LARRY BUHL

22

Reshaping children's HIV treatment

Pediatric HIV care evolves as studies explore remission, long-acting injectables and simplified regimens.

BY LARRY BUHL

24

How routine, opt-out screening led to 100% linkage to care at one FQHC network

From testing to treatment: Opt-out model improves HIV outcomes in high-need settings.

BY LARRY BUHL

25

The state of PrEP worldwide and new strategies for uptake

Funding cuts stall PrEP progress even as new options show high effectiveness.

BY LARRY BUHL

EVERY ISSUE

5

EDITOR'S NOTE

The science is the message

Ten years later, what we still need to understand about U=U.

BY RICK GUASCO

6

BRIEFLY

HIV criminalization on a global level. Monitoring HIV decriminalization by state. Gender-affirming clinics under attack. Navigating PrEP access. HIV testing and college students of color. Emergency measure returns ADAP eligibility to thousands in Florida. Ciara joins One2PrEP campaign to promote twice-yearly HIV prevention. Biktarvy is among the 15 drugs facing Medicare price negotiations.

BY ENID VÁZQUEZ

32

BEING BRIDGETTE

Community and clinicians meet

The pre-CROI Cure Research Community Workshop is a common ground for researchers and community

BY BRIDGETTE PICOU



A CHILDHOOD SPENT PLANNING A FUNERAL INSTEAD OF A FUTURE FRAMES AN ESSAY BY KIM CANADY, A SELF-DESCRIBED "DANDELION," BORN WITH HIV—REFLECTS ON A LIFE LIVED IN THE SHADOW OF THE VIRUS. "DAY BY DAY, ONE STEP AT A TIME, I HAVE TO REMEMBER THAT I'M HERE FOR A REASON," SHE WRITES. **PAGE 17**

COMING SOON

THE 30TH ANNIVERSARY

HIV DRUG GUIDE

WITH HIV DRUG CHART

JOIN IN THE
CONVERSATION



@posaware



inbox@
positivelyaware.
com

POSITIVELY AWARE
5537 N. BROADWAY
CHICAGO, IL
60640-1405

ALL LETTERS,
EMAIL, ONLINE
POSTS, ETC.
are treated as
letters to the
editor unless
otherwise
instructed.
We reserve
the right to
edit for length,
style, or clarity.
Let us know
if you prefer
not to have your
name or city
mentioned.

GET YOUR
SUBSCRIPTION
OR ORDER
BULK COPIES



SCAN THIS QR CODE
with your smart-
phone, or go to
positivelyaware.
com/subscribe



Don't miss yours—order now!

The 30th annual HIV Drug Guide will soon be shipping.

Order your copy or place your bulk order:

positivelyaware.com/subscribe



©2025 POSITIVELY AWARE (ISSN: 1523-2883) is published bi-monthly by Test Positive Aware Network (TPAN), 5537 N. Broadway, Chicago, IL 60640. TPAN is an Illinois not-for-profit corporation, providing information and support to anyone concerned with HIV and AIDS issues. POSITIVELY AWARE is a registered trademark of TPAN. All rights reserved. Readership: 100,000. For reprint permission, email inbox@tpan.com. Six issues mailed bulk rate for \$30 donation; mailed free to people living with HIV or who are unable to contribute.

We accept submission of articles covering medical or personal aspects of HIV/AIDS, and reserve the right to edit or decline submitted articles. When published, the articles become the property of TPAN, POSITIVELY AWARE, and its assigns. You may use your actual name or a pseudonym for publication, but include your name, email address, and phone number with your story. Although POSITIVELY AWARE takes great care to ensure the accuracy of all the information it presents, POSITIVELY AWARE staff and volunteers, TPAN, and the institutions and personnel who provide us with information cannot be held responsible for any damages, direct or consequential, that arise from use of this material or due to errors contained herein. Opinions expressed in POSITIVELY AWARE are not necessarily those of staff or TPAN, its supporters and sponsors, or distributing agencies. Information, resources, and advertising in POSITIVELY AWARE do not constitute endorsement or recommendation of any medical treatment or product. TPAN recommends that all medical treatments or products be discussed thoroughly and frankly with a licensed and fully HIV-informed medical practitioner, preferably a personal physician. A model, photographer, or author's HIV status should not be assumed based on their appearance in POSITIVELY AWARE, association with TPAN, or contributions to this journal.



EDITOR'S NOTE

Rick Guasco
@rickguasco

The science is the message

Ten years later, what we need to understand about U=U

It's been a decade since the launch of the U=U campaign.

Undetectable = Untransmittable. Its simple message is grounded in science: A person with HIV who has maintained an undetectable viral load for at least six months through successful HIV antiretroviral treatment does not transmit the virus to a sexual partner. Even before the U=U campaign, the principle was long known as “treatment as prevention”—TasP. The name's not as catchy, but the concept is the same.

Launched by Bruce Richman and the Prevention Access Campaign (PAC) in 2016, U=U has become one of the most consequential and successful HIV public health campaigns, writes Tim Murphy in his report that starts on page 10. The campaign helped prompt changes to HIV treatment guidelines and was used to repeal or modernize outdated state laws that criminalized people living with HIV if they did not disclose their status. And U=U has done much to address stigma—including internalized HIV stigma.

“It was very empowering,” says Todd Fuqua, an Indiana activist living with HIV, in Tim's story.

A 2021 study conducted in sub-Saharan Africa found that men who heard about and understood U=U were more likely to get tested for HIV. Another study reported that people with HIV who had conversations with their care provider about U=U had better rates of adherence to treatment and becoming undetectable. They were also more likely to inform their partners of their status.

But not everyone is sold on the message. In a 2024 online survey of mostly gay men in the U.S., 95% were aware of U=U, but only 41% believed it. Of the 457 participants, 106 were living with HIV; 351 were negative or had uncertain status. Two-thirds of the men with HIV believed in the science, compared to one-third of the men with negative or uncertain status. Among the skeptics, brief informational messaging about U=U did little to change their opinions. The study noted, “Interventions are needed to correct commonly held, outdated misconceptions about HIV transmission risk.”

And U=U has not reached everyone equally, says PAC interim executive director Monique Carry, PhD: “Awareness remains uneven across

regions, communities and healthcare settings. Provider resistance is still a real barrier. Outdated beliefs, fear of liability or discomfort with sexuality prevent providers from fully embracing or communicating U=U, despite the science being clear. In other settings, health systems have been slow to integrate U=U into training, counseling and public-facing materials, leaving clients to learn about U=U elsewhere or not at all.”

She adds that structural barriers like racism, criminalization, poverty, gender inequities and political hostility toward public health are all factors.

While the message of U=U is as simple as a bumper sticker—or a meme—it is settled science, but the details are nuanced.

There's a difference between being *undetectable* and *suppressed*. Both terms describe how much virus is in a person's blood. *Undetectable* means that the amount of virus in a person's blood is below a test's ability to measure—generally, less than 20 copies per milliliter (mL). But moreover, a person has to have remained undetectable for at least six months by having stayed adherent to their HIV treatment, whether that's oral medication or a long-acting injectable, to be considered *untransmittable*.

If your virus is *suppressed*—a viral load of less than 200 copies/mL—that's still low enough to be *undetectable*.

Elsewhere in the issue, in separate essays, two people born with HIV write about how the science of U=U changed their lives. Brandon Cox Sanford (aka standup comedian Andy Feds) recalls how he met his wife, Jasmine; they were married last December (page 16). As a child, Kim Canady planned her own funeral, not wanting to be a

burden on her family. Years later, she's married and the mother of a high school football player—both husband and son are HIV-negative (page 17).

Managing your health as you age can be complicated enough without HIV. Tim Murphy offers a cheat sheet that can help (page 19). Addressing the complicated relationship between HIV and sexualized drug use requires a syndemic approach, writes David Fawcett, PhD (page 30).

Our coverage of CROI 2026 (pages 24–27), written by Larry Buhl, highlights key presentations at one of the



largest HIV medical conferences of the year. Bridgette Picou attended the conference and writes in her column about how the pre-CROI Cure Research Community Workshop provides common ground for researchers and community.

The HIV community—those of us living with HIV, advocates, care providers and researchers—is stronger when we work together to find solutions.

You are not alone.

Rick



Briefly

ENID VÁZQUEZ  @enidvazpa



HIV criminalization on a global level

“In 2025, HIV criminalisation remained a persistent, global human rights and public health failure—visible both in the rise in reported prosecutions and in the continued mismatch between HIV science and legal practice,” writes the HIV Justice Network. The global organization released its annual report on HIV criminalization in January.

According to *HIV Criminalisation 2025 – A Year in Review*, “In the United States, **state-level action remained the primary driver of change**. In Maryland, the governor signed legislation repealing the state’s HIV-specific criminal statute, removing a law long criticised for its incompatibility with current scientific evidence. North Dakota also enacted legislation addressing outdated HIV criminalisation provisions, narrowing their scope and reducing the reach of HIV-specific penalties.”

Which country accounted for more than half of the 112 cases around the globe reported by the network? Uzbekistan.

“This is partly because Uzbek courts publish all HIV criminalisation cases online, but mainly due to an exceptionally broad and punitive legal framework combined with extensive mandatory HIV testing,” the report notes. Mandatory testing identifies people with HIV, unlike confidential testing, which keeps their identity private. This also helps them seek the care they need, but privately.

Some themes remained constant around the world, including law enforcement’s focus on marginalized groups such as gay men and trans women and on punishment for “no-risk conduct framed as intentional harm,” such as spitting cases.

The HIV Justice Network’s vision is “of a world where people living with HIV, in all our diversity, can enjoy our human rights and live in dignity, without fear of unjust criminalisation, regulation or control.”

GO TO hivjustice.net/news/2025-in-review-more-reported-cases-uneven-reform.

Gender-affirming clinics under attack

Three clinics providing gender-affirming care for trans-gender youth are now under investigation by the U.S. Department of Health and Human Services (HHS). HHS has basically declared war on such care. The three hospitals under scrutiny are the Seattle Children’s Hospital, Children’s Hospital Colorado and Children’s Minnesota.

A lawsuit filed in December against HHS for its negative stand on gender-affirming care for youth is helping limit further action against the clinics. **A comprehensive report from The 19th details**

the ongoing challenges: 19thnews.org/2026/01/gender-affirming-care-youth-hospitals. The 19th is an independent nonprofit news outlet focusing on “gender, politics, policy and power.”

Navigating PrEP access

Using PrEP—HIV prevention in the form of pills or long-acting injectables—can help people from acquiring the virus, but it can still be difficult to get the medication. An article from KFF (formerly the Kaiser Family Foundation) follows one man’s frustrations.

“When Matthew Hurley was looking to take PrEP to prevent HIV, the doctor

Monitoring HIV decriminalization by state

The Health Not Prisons Collective has launched an online bill tracker to monitor legislation tied to HIV criminalization and sex work decriminalization across the United States. The tool compiles state-level bills in the 2025–2026 legislative session, offering advocates **a centralized way to follow policy developments that affect people living with HIV**.

The tracker highlights bills that could either advance or undermine public health-centered approaches, says the HNP Collective, including legislation related to HIV exposure laws, sex work and broader criminalization trends. It also reflects an expanded scope: recent updates include monitoring proposals such as mask bans, which advocates warn may increase surveillance and policing of communities already disproportionately impacted by HIV.

Advocates are encouraged to submit additional legislation for inclusion, underscoring the project’s aim to build a more comprehensive, community-informed picture of how state laws shape HIV-related outcomes nationwide. The collective is an initiative led by organizations that include the Positive Women’s Network-USA and The Sero Project. GO TO healthnotprisons.org/bill-tracker. —RICK GUASCO



TOP OF THE NEWS

> HIV criminalization on a global level > Monitoring HIV decriminalization by state > Gender-affirming clinics under attack > Navigating PrEP access > HIV testing and college students of color > Emergency measure returns ADAP eligibility to thousands in Florida > Ciara joins One2PrEP campaign to promote twice-yearly HIV prevention > Biktarvy is among the 15 drugs facing Medicare price negotiations

hadn't heard of the medicine, and when he finally did prescribe PrEP, the bills sent to Hurley were expensive...and wrong. 'I decided to write in because the process was really super frustrating.' At one point, Hurley asked, 'Am I just going to stop this medication to stop having to deal with these coding issues and these scary bills?'"

The January 5 story details Hurley's journey and provides tips on how to get your PrEP and keep it coming. Titled "To Knock Down Health-System Hurdles Between You and HIV Prevention, Try These 6 Things," **the article includes information on how to overcome billing problems and educate your provider** (sadly, it's still an issue), along with a reminder to get your required lab work done in-network (so that it's covered by your insurer).

GO TO kffhealthnews.org/news/article/health-care-helpline-prep-preexposure-prophylaxis-hiv-prevention-drug-lgbtq-tips.

HIV testing and college students of color

Results of a survey of 110 students published in the *Journal of American College Health* show a lag between awareness of HIV and use of prevention resources.

"African American/Black and Hispanic/Latino college students experience disproportionate rates of HIV and other sexually transmitted infections (STIs) compared to their [w]hite peers, yet remain underserved by campus-based sexual health services," report authors

CONTINUES ON PAGE 8 >>

Emergency measure returns ADAP eligibility to thousands in Florida

Florida Gov. Ron DeSantis signed a bill, HB 697, restoring funding through June 30 to the state's AIDS Drug Assistance Program (ADAP), returning aid eligibility to about 12,000 recipients. The emergency law partially restores healthcare for Floridians with HIV who were thrown into a panic in January when the state's Department of Health (DOH) dropped the threshold for financial assistance for ADAP and removed Biktarvy from the ADAP formulary, citing a \$120 million shortfall caused by federal funding cuts. The new law is considered a stop-gap solution until lawmakers pass a new state budget for the 2026-27 fiscal year, which begins July 1.

What the new law does:

- Provides \$31 million to fund ADAP through June 30, 2026.
- Restores financial assistance, including co-pays, for ADAP recipients whose annual income is up to 400% of the poverty level (about \$62,600), from 130% of the poverty level, or only up to \$20,345, proposed in January.
- Directs DOH to assist with co-pays for Floridians on Medicare or employer-based insurance.

What the new law does not do:

- Reverse the restrictions on Biktarvy for ADAP recipients, nor does it relax the restrictions on Descovy.

- Restore premium assistance for the lowest-income Floridians.
- Affect people on private insurance or Medicare/Medicaid.
- Terminate any ADAP recipient's health insurance plans.
- Determine the long-term structure of ADAP after June 30.

New letters from DOH to ADAP recipients are expected to be sent soon. DOH is providing updates to ADAP at floridahealth.gov/individual-family-health/injury-prevention-wellness/hiv-aids/hiv-aids-management.

The new law also requires DOH to submit monthly reports detailing all federal revenues and expenditures to the Senate Appropriations Committee and House Budget Committee. The reports must itemize manufacturer rebates, enrollment figures by county, prescription utilization by drug class and projected funding deficits. This provision offers transparency, which advocates say has been sorely lacking from DOH.

Michael Rajner, a volunteer HIV activist from Fort Lauderdale who has spent months commuting to Tallahassee to urge legislators to reverse the ADAP, expressed relief at the passage of the stopgap bill but shared some bitterness about DOH.

"The community has risen up and legislators listened," Rajner told POSITIVELY AWARE. "But the Department of Health has not been—and is still—not transparent."



Where to find help

Because the law is a temporary solution and only valid for little more than three months, people on ADAP who still fall short on paying their premiums are encouraged to shop for more affordable plans during the special enrollment period, which ends April 30. Covering Florida, the state's navigator for Affordable Care Act plans, can offer assistance in finding new coverage.

In addition, people in Miami-Dade County may have additional assistance, thanks to a proposed resolution that would provide \$1 million to ADAP services. For people who are uninsured, a database can help locate health centers.

Gov. DeSantis signed the measure on March 24. Advocates say their efforts to restore full ADAP services for Floridians will continue, as the fate of premium assistance for the upcoming fiscal year is still in question. Budget negotiations are expected to start in April, just as the 2026 election season heats up. —LARRY BUHL

>> CONTINUED FROM PAGE 7
Nmesoma F. Anya, BSN, and
Jaquetta M. Reeves, PhD.

“National data indicate that individuals aged 18–24 years account for nearly half of all new STIs in the United States, and racial/ethnic disparities persist across all major infections. Structural barriers—such as stigma, limited access to testing and lack of culturally relevant education—further hinder prevention efforts among minority student populations.”

Their study found that, “Despite being sexually active, the majority of participants reported never undergoing testing for HIV (74%, or 81 students) or other STIs (68%, 74 students). Given that people ages 18–24 account for a large share of STI transmission, this finding points to a missed opportunity for early detection and prevention.”

When participants were asked specifically about certain measures of sexual health, the survey found:

- awareness of [HIV] self-sampling kits (23.6%) and PrEP [medication used for HIV prevention] (18.2%) was low
- inconsistent condom use was common
- only 2.7% had used a kit

Still, most of the students said they recognized that young adults are vulnerable to HIV (91.8%) and STIs (97.3%).

“Expanding culturally relevant education, PrEP outreach and self-sampling access is essential to advance sexual health equity,” Anya and Reeves state in their conclusion.

The survey of students at a large public university in North Texas (64.8% were Black and 35.2% Hispanic/Latino) was completed anonymously online in 2023.

To read the report,” published online December 30 and available as open access (free), [GO TO \[tandfonline.com/doi/full/10.1080/07448481.2025.2607140#abstract\]\(https://doi.org/10.1080/07448481.2025.2607140#abstract\)](https://doi.org/10.1080/07448481.2025.2607140#abstract).



GRAMMY-WINNER CIARA (SECOND FROM LEFT), MEDIA PERSONALITY LOREN LOROSA AND HIV ADVOCATE DR. LEO MOORE AT THE AMPLIFYING HIV PREVENTION THROUGH POP CULTURE AND MUSIC PANEL AT SXSW IN AUSTIN, TEXAS.

Ciara joins One2PrEP campaign to promote twice-yearly HIV prevention

One office visit every six months, two times a year for HIV prevention—that’s the message of a recently unveiled national advertising campaign with music based on Grammy Award-winning singer Ciara’s 2004 dance hit 1, 2 Step, with rapper Missy Elliott and producer Jazze Pha.

Launched during the Super Bowl Pregame and the Grammy Awards, the peppy commercial featuring men and women, cis and trans, straight and gay helps with one problem plaguing HIV PrEP: lack of awareness.

“There was a nostalgic feeling with this campaign because I remember back in the day the conversation was really big surrounding HIV and AIDS,” Ciara told *Time* magazine in a video interview. “The awareness level was really high, and I think over time it subsided a little bit and those conversations fell to the wayside. But the reality is that **this disease is still rolling strong and there’s so much opportunity for people to protect themselves**.... Talk about the PrEP shots alone. It’s groundbreaking. We’re talking about game-changing science. Wherever there is an opportunity where I can

impact someone’s life and essentially help save a life, I’m going to be first in line to do it because I feel an obligation to do that with my platform. I just don’t think that I’m given this amazing platform to just sing and dance.”

The campaign promotes Yeztugo, the long-acting HIV prevention medication from Gilead Sciences, which came on the market last year.

“I just thought, ‘This is such an amazing opportunity where you get to see the power of music coming together with the power of medicine, essentially, but ultimately you see impact on someone’s life,’” Ciara told *Time*.

She re-recorded part of her song for the campaign.

“PrEP is not solely for gay people,” said Leo Moore, MD, MSHPM, AAHIVE, at a Gilead-sponsored panel that included Ciara, held at the South by Southwest (SXSW) festival in March, in Austin. As reported by The Grio news site, Dr. Moore explained, “There are many heterosexual men and women who can benefit from PrEP that aren’t considering it because they think it’s solely for the LGBTQ+ community. So, this is ensuring that folks

are aware that the [Centers for Disease Control and Prevention] recommends that everyone, adults and adolescents who are HIV-negative, consider PrEP.”

Dr. Moore has served on the Presidential Advisory Council on HIV/AIDS (PACHA).

“I want for my people, and beyond, to understand that there are ways to protect yourselves when you’re out there and you’re curious and you’re dating,” The Grio reported Ciara as saying. “[Once you] take things to new levels physically, you need to know that there are ways to protect yourself on that journey...let’s have conversations. Let’s take away the stigmas or the funkiness of these types of conversations.”

One during your winter glam and one during your summer glow. One during your wintertime and one during your summer shine. To see the Yeztugo One2PrEP commercial, [GO TO \[youtube.com/watch?v=ssBBnGZQfxM\]\(https://www.youtube.com/watch?v=ssBBnGZQfxM\)](https://www.youtube.com/watch?v=ssBBnGZQfxM). Catch the original dance extravaganza at [youtube.com/watch?v=iBHNqV6_znU](https://www.youtube.com/watch?v=iBHNqV6_znU). To read The Grio’s report, [GO TO \[thegrio.com/2026/03/19/ciara-says-protecting-your-sexual-health-is-a-1-2-prep-process\]\(https://thegrio.com/2026/03/19/ciara-says-protecting-your-sexual-health-is-a-1-2-prep-process\)](https://thegrio.com/2026/03/19/ciara-says-protecting-your-sexual-health-is-a-1-2-prep-process).

Biktarvy is among the 15 drugs facing Medicare price negotiations

The most widely used HIV medication is the first HIV drug selected for Medicare's Drug Price Negotiation Program

BY RICK GUASCO



Biktarvy, the commonly prescribed single-tablet regimen for treating HIV, is among the 15 drugs that will face Medicare price negotiations this year aimed at significantly reducing program expenditures and out-of-pocket costs for Medicare beneficiaries.

Release of the January 27 list kicks off a process that will unfold throughout most of 2026 and involve participation by drug companies and the public.

The Centers for Medicare & Medicaid Services (CMS) announced the 15 drugs covered by Medicare Part B and Part D as the third annual cycle of the Medicare Drug Price Negotiation Program, part of the Biden-era Inflation Reduction Act. Under the federally mandated program, CMS directly negotiates the prices of some high-cost drugs, focusing on single-source drugs that have no generic version or direct competitor.

This is the first time an HIV medication has been selected for the Medicare Drug Price Negotiation Program.

CMS looked at Part B and Part D drug expenses

between November 1, 2024 and October 31, 2025, to determine which drugs to choose. The selected drugs accounted for \$27 billion in total expenses to Parts B and D, for about 1,777,000 beneficiaries who were given the medications for conditions that included cancer, psoriatic arthritis and HIV. Biktarvy cost Medicare about \$3.9 billion for 101,000 beneficiaries during that period, according to a CMS fact sheet.

Makers of the 15 drugs had until February 28 to decide if they would participate in price negotiations with CMS.

March 1 was the deadline for drug companies and the public to submit data. By then, drug companies will need to have submitted manufacturer-specific data to CMS to make their case for what the Maximum Fair Price

(MFP) should be for their drug. Also by then, the public must have submitted data on the selected drugs and their therapeutic alternatives, if any, as well as data on unmet medical needs, impacts to specific populations and other considerations.

CMS planned to host a series of patient-focused and clinical-focused public engagement sessions in April, including patient-focused combined roundtables on all 15 drugs. Patients, patient advocacy organizations and caregivers were invited to offer patient-focused input.

Early summer will see CMS negotiating with participating drug makers over the MFP, with CMS submitting an initial price offer on June 1; manufacturers are expected to accept CMS' initial offer or submit a counteroffer by July 1. A final MFP offer from CMS is expected by September 30; drug companies will have until October 31 to accept or reject the final offer. Negotiations are set to end November 1. CMS is expected to publish any agreed-upon MFPs by November 30. MFPs will go into effect January 1, 2028.

Gilead is expected to be most impacted by any new negotiated Medicare drug pricing, say healthcare industry analysts. According to a report by CNBC, one analyst estimated that Medicare revenue from Biktarvy could represent about 8% of Gilead's total projected worldwide sales for 2027.

For 2024, the latest year for which figures are available, Gilead reported global sales of Biktarvy at \$13.4 billion, about a 13% increase over 2023. The company reached an agreement with generic drug manufacturers, delaying Biktarvy's entry into the U.S. generic market until April 1, 2036; the CMS negotiations could challenge that.

Here's the complete list of the 15 drugs up for negotiation this year under the Medicare Drug Price Negotiation Program:

Anoro Ellipta - chronic obstructive pulmonary disease, made by GSK
Biktarvy - HIV, made by Gilead Sciences
Botox and Botox Cosmetic - several cosmetic and therapeutic uses including chronic migraines, made by AbbVie
Cimzia - rheumatoid arthritis, Crohn's disease and other autoimmune conditions, made by UCB
Cosentyx - autoimmune conditions including plaque psoriasis, made by Novartis
Entyvio - active ulcerative colitis and Crohn's disease, made by Takeda
Erleada - prostate cancer, made by Janssen Biotech
Kisqali - breast cancer, made by Novartis
Lenvima - several advanced cancers, made by Eisai
Orencia - rheumatoid arthritis and psoriatic arthritis, made by Bristol Myers Squibb
Rexulti - schizophrenia, Otsuka Pharmaceuticals
Trulicity - Type 2 diabetes, Eli Lilly
Verzenio - breast cancer, Eli Lilly
Xeljanz and Xeljanz XR - rheumatoid arthritis and multiple other inflammatory conditions, made by Pfizer
Xolair - asthma and other allergies, made by Genentech



10 Years of the U=U campaign: Where it's succeeded—and fallen short

Publicizing that people with fully treated HIV can't transmit it sexually has reduced stigma and even changed criminalization laws—but the concept still faces widespread ignorance and disbelief.

BY TIM MURPHY

It was 10 years ago last winter in Boston, at the Conference on Retroviruses and Opportunistic Infections (CROI), that Bruce Richman, a New York City-based philanthropic adviser with a Harvard law degree, and Gus Cairns, a longtime HIV advocate and journalist from the U.K., had a heart-to-heart. Both living with HIV, they lamented that it wasn't commonly known worldwide that people with HIV who take antiretroviral medication and maintain an undetectable viral load cannot transmit the virus sexually. That fact had been definitively proven by a series of large studies published throughout the 2010s. But too few people—among them people living with HIV, their care providers, advocates and the general public—had any idea.

So a few months later, Richman launched the Prevention Access Campaign (PAC) to spread the word, abbreviating the slogan “Undetectable = Untransmittable” to the simple, catchy “U=U.” By the end of 2016, with even more data to back up the science, New York City's health department became the first in the world to officially endorse and promote U=U (with an outdoor dance party the following spring, no less). Federal health agencies started making videos to promote U=U. In the

ensuing years, U=U would be publicly embraced by dozens of governments and health agencies worldwide, with the U.S. Centers for Disease Control (CDC)—at the time, the world's most respected public health agency—announcing that people with HIV with suppressed virus on meds posed “effectively no risk” of passing the virus to their sex partners. (For U=U purposes, suppressed—or undetectable—viral load means less than 200 copies/mL.)

It was a huge sea change,

dramatically reducing the stigmatizing idea of people living with HIV as a vector of disease. Dissemination of the U=U message changed HIV treatment guidelines and helped repeal or soften longstanding laws in about half of U.S. states that criminalized people with HIV for not disclosing their HIV status to partners. It was also a huge self-esteem lift for people living with the virus worldwide.

“It was very empowering,” says Todd Fuqua, an Indiana activist living with HIV. “It removed a layer where [people with HIV would think of themselves] ‘I'm broken, I'm a threat, I'm dangerous, I'm sick.’ It really helped our outlook on life and relationships.”

A decade in, though, the U=U campaign has not accomplished all it intended to. Studies show that many people—living with HIV or not—haven't heard of the idea behind U=U or they don't believe or trust it, even in the face of ample data. In scientific communities, and in U.S. HIV care guidelines, it's known as Treatment as Prevention (TasP). Only five states have fully repealed their HIV criminalization

Undetectable means untransmittable

—but the world is still catching up to that truth.

laws, with 32 states still criminalizing people with HIV—28 states still have harsh enhanced penalties for people with HIV. And though individuals, groups and governments in countries worldwide continue to robustly promote U=U, here in the U.S., the momentum behind U=U, which was aided by both the Trump 1.0 and Biden administrations, has slowed amid the Trump 2.0 administration's widespread rejection of longstanding global research and public-health best practices.

Where has U=U succeeded and where has it failed in the past decade? And what comes next? Let's take a look.

On one hand, an astounding success

It's hard to underestimate the reach of a campaign that was started by two individuals without initial support from major agencies or institutions. According to PAC, since its launch in 2016, the U=U message has been officially adopted by more than 1,100 organizations or agencies in 108 countries. It has shot across social media worldwide, often appearing before the eyes of people who are outside of the global HIV activist community, who had no idea that people living with HIV on meds were unable to transmit the virus sexually. And as Fuqua noted, it has empowered people with HIV across the world to be more open and unashamed about their status.

"Over the past decade, the U=U movement has had profound global impact by revolutionizing what it means to live and love with HIV and accelerating progress toward ending the epidemic," Richman, who recently left the organization he founded to pursue other projects, wrote in an email. "It has transformed public understanding and personal lives by reducing fear, stigma and misinformation, reshaping clinical practice, reforming discriminatory laws and policies and offering millions of people living with HIV a new sense of freedom from the fear of transmission."

He was echoed by PAC interim executive director Monique Carry,

PhD, who wrote in an email: "Over the past decade, U=U has fundamentally changed how we understand HIV, not just scientifically, but socially. It has reshaped clinical guidance, influenced policy and advocacy and transformed provider-patient conversations in many settings. In health systems that have embraced U=U, we've seen more affirming counseling, better engagement in care and a shift away from fear-based messaging. For many people living with HIV, U=U has restored a sense of agency, opened the door to relationships and family planning and reduced internalized stigma in ways no other public health message has done."

She continued: "U=U has also helped move conversations about HIV criminalization, disclosure and rights toward evidence rather than moral judgment. Perhaps most importantly, it has demonstrated the power of a movement led by people living with HIV who insisted that the science be communicated honestly and without fear."

Clinicians agree, too, that U=U has had an impact. "The biggest thing it's done is to further drive us, as a field, to emphasize how critical it is to get fully suppressed," says Jeanne Marazzo, MD, MPH, FACP, FIDSA, the CEO of the Infectious Disease Society of America

A 2020 study of thousands of people with HIV in several countries who have discussed U=U with their health provider—which is often when they are most likely to absorb and believe new health information—had better outcomes in terms of adherence to their meds, getting to undetectable and disclosing their status to sexual partners.

And at least one study has also shown that knowledge of U=U makes people with unknown HIV status more likely to get tested. Fuqua says he learned this fact through PAC's "U=U University" initiative, which educates providers and advocates and prepares them to pass on the message.

"That was an a-ha moment for me," says Fuqua, noting that the study suggested that people were more likely to get tested because, after learning about U=U, the idea of HIV as a fairly easily managed virus that can be rendered untransmittable "doesn't seem so scary."

According to Bruce J. Packett II, executive director of the American Academy of HIV Medicine (AAHIVM), U=U has "served as a foundational element for status-neutral care." By that he means care that informs people living with HIV about the benefits of being adherent to meds and maintaining an undetectable load, while informing people who do not have

HIV, but who have the potential for acquisition, of available prevention

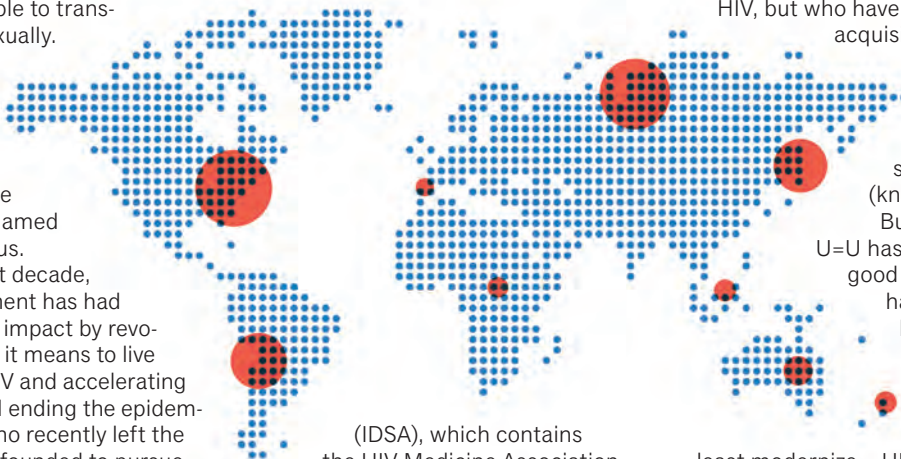
options such as condoms and preexposure prophylaxis (known as PrEP).

But perhaps where U=U has done the most good in reducing harm to people living with HIV is the key role it has played in efforts to repeal—or at

least modernize—HIV criminalization laws so that they reflect current science. Often written in the 1980s and '90s at the peak of the epidemic, HIV criminalization laws penalize people with HIV who don't disclose sexually even if no HIV was transmitted—or impose an additional harsher sentence in some cases if the person charged has HIV. Many of these state laws have remained on the books even after highly effective

(IDSA), which contains the HIV Medicine Association (HIVMA). "You can tell people now that if they fully adhere to their meds, they can be non-infectious to their partners. That's such a powerful message that changes the game of motivating people [to take] antiretrovirals. HIV was once a death sentence, but now you can live a full life, whether it's wanting to have a healthy sex life or a child."

Her words are backed up by data.



antiretroviral treatment has become the norm since the late 1990s.

Since the 2016 rollout of U=U, at least 13 states have either repealed or softened their HIV criminalization laws. "I'd say that in every one of those changes, U=U played a significant role," says Kamaria Laffrey, co-executive director of The Sero Project, which advocates for such changes in HIV laws. "Without the science and the campaign behind U=U, we can't express [a core reason why these laws should be changed] in a clear way."

But Laffrey says that she, like many advocates against HIV criminalization, has been careful not to make U=U the linchpin for law change because some people with HIV are either unable or unwilling to get and stay undetectable—for complicated reasons that can include mental illness, substance use, unstable or nonexistent housing or healthcare or a combination of these. That's why advocates have pushed for law changes to be based not only on undetectability but, for example, on shifting the burden of proof of *intent* to transmit HIV to the accuser.

"That's why I don't lead with U=U" in her law-change advocacy, says Laffrey. "I don't want to create legislation that would hinge [being protected from charges] on being undetectable."

But on the flip side...

The simple fact remains that, as much as the U=U campaign has gotten its message out globally over the past decade, vast swaths of people in healthcare, the legal system and the general public—including people living with HIV—haven't heard of the concept (if they even know what *undetectable HIV* means) or, if they have, don't believe it or entirely trust it.

Science has moved forward—but many laws haven't.

This is borne out by research. One 2024 survey found that among about 106 mostly gay white men living with HIV and another 351 living without HIV or of unknown status, about 95% of all participants were aware of U=U, but only 41% believed it. Among men living with HIV, two-thirds (66%) accepted U=U, compared with about one-third (33.6%) of those who were HIV-negative or of unknown status. (The study concluded that society could benefit by broader and deeper promotion of the U=U message.)

A 2022 survey found that, of more than 700 people living with HIV—most of them cisgender men under age 50 with some college education—more than half didn't know the meaning of U=U. But for those who did, more than half learned it from their health provider, not from informational campaigns, which points to the importance of provider education on U=U so they can pass the knowledge on to patients.

And a 2024 study of mostly older Black low-income heterosexual people in South Carolina found that most of them didn't believe or trust the U=U message (particularly if they hadn't heard of U=U previously). Wrote the study authors: "These findings are of grave importance to the fight against the HIV epidemic in the U.S., since belief or confidence in U=U could help reduce sexual HIV transmission, reduce HIV-related stigma, promote adherence to ART and improve the general well-being of [people with HIV]."

Leaders in U=U messaging echo this.

"U=U's impact has been uneven," Richman wrote in his email. "It has not fully reached communities where there is a lack of bold leadership and a persistent devaluing of the lives of people living with HIV, especially those already marginalized by health systems. This gap exists because





stigma, inequity and chronic underinvestment in public health continue to shape who benefits most from scientific progress. There is also still limited understanding of U=U's value beyond individual health, including its broader social, economic, public health and prevention importance. And this is true on every continent. Until both the personal and public health power of U=U are fully understood and embraced, its promise will remain only partially fulfilled."

Wrote Carry in her email: "U =U has not reached everyone equally. Awareness remains uneven across regions, communities and healthcare settings. Provider resistance is still a real barrier. Outdated beliefs, fear of liability or discomfort with sexuality prevent providers from fully embracing or communicating U=U, despite the science being clear. In other settings, health systems have been slow to integrate U=U into training, counseling and public-facing materials, leaving clients to learn about U=U elsewhere or not at all."

She added: "Making U=U a reality for everyone also falls short where access to treatment is fragile or inconsistent. Structural barriers like racism, criminalization, poverty, gender inequities and political hostility toward public health continue to shape who can benefit from U=U in practice."

In Indiana, says Fuqua, even the best presentation of U=U has not been enough to get the state's HIV criminalization laws reformed. **"We see many cases where people plea-bargain and are charged even though they're undetectable," he says. "We haven't done our job in [sufficiently] educating the public defenders, prosecutors and judges"** about U=U.

And Indiana is just one of many states where the U=U message hasn't been enough to reform such laws.

But Fuqua notes that U=U's insufficient reach isn't just in the legal space.

"I think it's been adopted in [HIV] clinics faster than it's been absorbed by general culture. Beliefs spread more slowly than evidence, so it's hard to change people's minds. And **I think there are still providers out there who hedge a little or stay silent on U=U**" with their patients, he

says, perhaps because of some gut mistrust or because they still don't want their undetectable patients having sex without a condom.

What happens now?

Experts agree that, with the Trump 2.0 administration abruptly abandoning standard, evidence-based public health measures both at home and abroad, now is probably not the best time to expect the federal government to carry the torch for U=U as it did under Trump 1.0 and Biden. And they worry that the full potential of U=U—getting more than 90% of Americans with HIV to undetectable as a means of effectively ending the HIV epidemic in the U.S.—is truly threatened now that both huge impending cuts to Medicaid and the end of subsidies for Obamacare plans threaten to throw countless Americans, some living with HIV, off health coverage entirely. (Deep-red Florida, with a large HIV population, has even gone so far as to drastically scale back income eligibility for its AIDS Drug Assistance Program (ADAP), each state's payer of last resort for HIV meds and care.)

Laffrey says she worries that deep cuts to HIV prevention funding the past year will lead to more HIV cases—and more people living with HIV who are unaware of U=U. "I think the science is going to take a hit and we'll have to start all over again. We have no federal partners right now, so I think our advocacy will become more localized around making sure that people stay in care."

But even though the current climate may not be optimal for continuing to get the U=U word out, Carry says that PAC will be,

well, carrying on—including soon launching a "10 Years of U=U" campaign across its social media channels. There, she wrote, "we'll be sharing stories, partner highlights, events and milestones," building to a crescendo for a strong U=U presence at the AIDS 2026 International AIDS Conference in Rio de Janeiro in late July.

"For example," she wrote, "last month in partnership with The Global Network of People Living with HIV (GNP+), "we hosted two global webinars"—one for leaders across the Americas and West Africa and another for Europe, Asia and East Africa.

Other components of the campaign, she wrote, will include a digital storytelling series highlighting U=U's impact over the past decade, U=U University and capacity-building activities, a 10 Years of U=U Awards Celebration Dinner, the unveiling of the U=U Youth Manifesto developed with Y+ Global at AIDS 2026 and ongoing digital and social engagement spotlighting regional and partner-led efforts.

"Looking beyond 2026," she wrote, "our focus is on durability: embedding U=U in education, practice and leadership so that it can withstand political cycles and continue advancing access and truth."

"They've been doing a good job of it already for the past 10 years," he says. "They're the heroes in this story." **PA**

...our focus is on durability: embedding U=U in education, practice and leadership

When Brandon met Jasmine

Born with HIV, newlywed Brandon Cox Sanford (aka Andy Feds) says, 'I choose not to let HIV limit how I define me'

BY BRANDON COX SANFORD ("ANDY FEDS")

Life is funny. I met my wife, Jasmine, on the dating app Upward. This was during a time where I had to completely start my life over from the ground up. I had just lost my house, my job and even my dog, Wheezie.

I remember one day when I was on my knees, praying to God for a fresh start of happiness. I saw Jasmine on Upward and knew immediately that my prayers were answered.



I devised a plan to propose on the court at a Las Vegas Aces WNBA game

We talked for a bit on the app until I gave her my number. I always thought that when I go on dates, I want the girl to like me for me and not think of me as someone living with a virus. I didn't need to start off by saying, "My name is Brandon 'Andy Feds' Cox Sanford, and I was born HIV-positive." I've already had it happen before—rejected for being born with a virus I had no control of contracting. It hurts!

We texted for a quick time and then the moment of truth had to happen. I called her and told her about my HIV status. Anyone who knows my advocacy work as Andy Feds knows that I'm very open about sharing my status to help eliminate stigma surrounding HIV/AIDS. But

with dating, I had to be careful not to scare someone like Jasmine away.

I told her my status and waited for the explosion of negative results like a grenade, and to my surprise, nothing. She was shocked, don't get me wrong. However, she informed me that her time in the medical industry taught her a lot about HIV/AIDS and that she was fine with pursuing our budding relationship.

Shortly afterwards, Jasmine moved from Philadelphia to Las Vegas, where I live. I helped her move and we haven't left each other's side since! Our chemistry was building and as time went on, HIV was the last thing on our minds.

Well... not completely. Jasmine has volunteered to be a part of my advocacy work on social media, where I create funny videos to teach viewers about HIV/AIDS. At first, she was very camera shy. After a while, I noticed how quickly she got the hang of being in front of the camera. It's now gotten to the point where, every time she's on video with me, we get more engagement.

This also comes with the negatives. Of course, we've faced ignorance as people will try to attack us because we are a mixed-status (or sero-different) couple. She's been amazing in dealing with the negative people. Pun intended.

All of these things, I realized that I think I finally have the woman of my dreams. There was only one thing that I needed to do—ask her to marry me.

Seven months before,

I devised a plan to propose on the court at a Las Vegas Aces WNBA game—one of our first dates as a family with her son and daughter.

I'm a teacher. My students helped me come up with a plan to get her to do a trivia game in front of thousands of people. We've even created posters to let the audience know that Jasmine and I were about to be engaged.

The week before the proposal, I even somehow met A'Ja Wilson, the Aces star player, at Walmart. She was just randomly shopping and no one noticed her but me. If that wasn't a sign, I don't know what is!

The day of the proposal went as smoothly as planned. She said yes.

We planned our wedding for this past December 12.

That day has significance because Jasmine's birthday is December 11 and my birthday is the 13th. So it only made sense to have our wedding on that day!

The wedding was beautiful and it made me think of words society put in my head as a kid. I was told that I should only date people living with HIV/AIDS because of my HIV status. No disrespect to anyone living with HIV/AIDS, but my goal wasn't to find someone with HIV/AIDS. My goal was to find my dream girl. HIV wasn't a factor.

If there's anything I can say to anyone reading this, it's: *Do not define yourself based on your obstacles.* Your worth is however you define yourself. I choose not to let HIV limit how I define me.



PHOTOS COURTESY OF BRANDON SANFORD COX

The perfect funeral

'Being born with HIV meant expecting the worst—I choose to live instead'

BY KIM CANADY

Most little girls spend their years planning what their wedding would look like. The dress, the colors, the food, the music that will be playing—all of the bells and whistles. I was the opposite. I was planning my perfect funeral. There was a time when I had planned out what my funeral would look like because I knew I didn't want to be a burden in the afterlife. I knew how I wanted my hair, nails, outfit, coffin and what funeral home I wanted it to be at. I knew who was to speak—and definitely who was not—because my family and friends would go off on the microphone for 20 minutes singing off-key. I knew how I wanted my service and how I wanted the repast. I planned my funeral better than my own wedding that I never did get. I think about that a lot. I planned so hard for that time in my life that I let time around me pass without a *life* plan. How can you plan a life when you're so scared that death is just around the corner?

Loss was all around me, from being a child attending funerals for my grandmother's friends to then attending my parents', my friends' and my grandmother's funeral and then preparing for my own. I never thought that I would have the life that I have now, A wife, mother or even a college graduate. Being born with HIV at the beginning of the AIDS epidemic made life feel so bleak.

Not knowing what was going to happen to the people around you or even to yourself is one of the most unsettling feelings to have. I got to witness how everyone looked like themselves one day and literally a month later seeing the joy and their entire life force stripped from them to the point where they couldn't recognize themselves or who they had been. By the age of 25, I had been to over 25 funerals of friends who had lived with

HIV; by the time I reached 27 I just stopped counting and stopped going to them as well. The pain from losing everyone, coupled with survivors' guilt and questioning my existence, was too heavy to bear.

I feel like this is the part of the movie where everything fades to black and a mellow yet uplifting instrumental starts to play with the words *10 years later...* slowly appears on the screen. As it fades out you see me married, with my son happy and filled with joy, holding hands somewhere in the park. I really wish that was the case, but I'm still struggling every single day to live for myself and to plan for the future.

Day by day, one step at a time, I have to remember that I'm here for a reason. I'm in a constant fight with myself to not just be alive but to actually live! For me, living is going to my son's football games and loudly cheering



him on because I know that growing up, I never thought it was possible for me to have a child who wasn't born with HIV. Living, for me, looks like learning how to drive at the age of 35 so I can drive myself to the supermarket and hide in the parking lot and eat the food that I don't want to share with my family. Living, for me, looks like me finally applying to grad school and not being scared that I will die before I finish. Living, for me, is actually planning out that wedding and walking down the aisle

because 14 years of marriage deserves to be celebrated. Last but not least, living for me is not dreading my birthday.

Every year I get so mad and so heartbroken that I'm not living up to the pact my friends and I created about celebrating our milestones. So, I'm going to make that plan and celebrate. Grieving is the easy part. Living your life is the hard part, and that's what I'm choosing to do instead of waiting for that perfect funeral day to happen.

There was a time when I had planned out what my funeral would look like because I knew I didn't want to be a burden in the afterlife.

Your cheat sheet for aging optimally with HIV

Have you had these conversations or asked for these tests and screens from your provider?

BY TIM MURPHY

Coming up on 60 nearly two years ago, Manhattan's Mayfield Phillips, diagnosed with HIV in 1994, told his primary care provider that he wanted to do a series of simple, in-office strength, balance and cognitive tests to have a baseline to refer against in the years to come. He particularly wanted to do them because of more than two dozen surgeries he'd had on his brain related to his hydrocephalus ("water on the brain") going as far back as 1980 all the way to 2008, his last such procedure.



MAYFIELD PHILLIPS

The in-office tests revealed that, in his words, "I was performing above-average for an adult male my age." That left him feeling good. "I have this baseline to compare against now if I start to have changes in my thinking or movement that are

worrisome." He also has regular screenings for various cancers, some of which have been shown to have higher rates in people living with HIV, such as anal, cervical, lung and oral cancers.

All these measures should be part of the standard of care for folks aging with HIV—not to mention, for the most part, most folks aging *without* HIV—and yet how much they are acted upon can vary based on provider knowledge of this issue. That's why it's so important, if your provider is not bringing up these issues once you're past 50 or especially past 60, that you bring them up proactively. In recent decades, research has shown that HIV, largely because of the chronic inflammation it causes even when medically suppressed, can be an independent factor for accelerated aging in areas including cognition, mental health, bone health, frailty and cardiovascular health.

But it can be hard to know the real-life potential damage HIV can cause in these areas because it's mixed in with factors that determine everyone's health as they age, such as quality of and access to health care, diet, exercise and social connectedness. Hence the importance of having

conversations and screenings with your provider that help determine the overall health of the whole you—not just you as a person living with HIV—as you age.

According to Meredith Greene, MD, a professor of medicine at Indiana University School of Medicine who also sees hundreds of people living with HIV age 50 or over, it's common that her patients "have multiple chronic conditions—not just HIV—and are often on multiple medications and can sometimes feel overwhelmed by their pill burden and complexity." Heart complications, a history of strokes and diabetes are among the issues alongside HIV that she often sees in her patients.

She is echoed by Jonathan Appelbaum, MD, medical director at Carepoint Health and Wellness in Tallahassee, Florida, which serves more than 1,000 people living with HIV, most of them age 40 or older.

"Because of all the good HIV treatment we have these days, most of my patients have aged well with the virus and their treatment for it is very simple," he says. "So HIV itself is probably the least of their major medical issues. They're coming in with other things," he says, from diabetes, high blood pressure (hypertension) and elevated lipids (high cholesterol) to loneliness and social isolation.

If you're not already having the conversations, tests and/or screenings for the issues below, and if you're over 50 (but especially over 60), consider initiating them with your primary care provider at your next visit—or even schedule a visit just to go over them if you can. You can always print and bring this article, or refer them to these guidelines published by the National HIV and Aging Initiative, a joint project of the American Academy of HIV Medicine, ACRIA and the American Geriatrics Society.

And keep in mind that your HIV specialist may not be a geriatric specialist as well—hence all the more need to address these issues:



Basic mental and physical function tests.

Ask your provider if they—or someone they know they can refer you to—can perform some of the simple in-office cognition, balance, strength and mobility tests that Phillips mentioned. For cognition, these include the 3-minute Mini-Cog, the 5–10-minute Mini-Mental State Examination and the 10–15 minute Montreal Cognitive Assessment. Strength and/or frailty, mobility and balance can be assessed with tests like the Clinical Frailty Score, the 30-Second Sit to Stand Test and the Four-Stage Balance Test.

You should talk to your provider about cognition tests especially if "you feel you're having a change in your memory or cognition," says Greene. "It might be improved with a simple thing like adjusting a medication or a diagnosis of sleep apnea, which is treatable."

Also, if you are on a lot of meds and feel overwhelmed, Greene suggests that you ask your provider for a medication review. "Go through all of them," she says, "and ask, 'Why am I taking this? Do I still need it? Is there an interaction with other meds?'"



Tests that require blood draws

or diagnostic tools. These include measures to test for cardiovascular disease, bone health (DEXA or DXA scans), cancers or precancerous growths (including anal, cervical and lung, especially if you have a history of smoking) and metabolic organ function (kidney, liver and diabetes). These could also include one-time or seasonal vaccines for illnesses including COVID, the flu, pneumonia and shingles.

Greene notes that not all providers have the in-house resources to do all these tests, such as for anal cancer or precancer or DXA scans. If that's the case, urge your provider to partner with a specialist elsewhere to help you get the results.



Mental health. Your provider should ask the extent to which, and how often, you are feeling depression and/or anxiety or having symptoms that could indicate them, such as difficulty sleeping, loss of appetite or lack of interest in doing things that usually bring you pleasure and joy, such as getting together with family and friends. (Some providers even do this with a short questionnaire they ask you to take when you arrive.)

Whether or not your provider asks you these questions, if you've been feeling particularly anxious or depressed, bring that up with them. Options to help alleviate depression and anxiety include better sleep practices, healthy eating, exercise and more social connectedness to talk therapy and/or medications.

Speaking of social connectedness: Ample research has shown that isolation and loneliness as we age can lead

"I feel that I'm approaching aging with HIV from a very empowered place,"

to or exacerbate poor physical and mental health and can cut into longevity. According to Appelbaum, many providers screen patients for this with the UCLA Loneliness Scale,

which asks, for example, how often you feel that you lack companionship, feel left out or feel isolated from others. But he admits, "As providers, we've probably not done a great job of incorporating this into our practice."

Indeed, your own provider may not spark this conversation—but if you're experiencing loneliness, you should bring it up. Maybe a simple conversation with someone like your provider, or a social worker they connect you to, will help you clarify how you might get more social interaction—even if you have disabilities that limit your social life. For example, consider calling your nearest AIDS services organization. They may have groups, events or counseling opportunities for which they can arrange transportation so you can come. And if you're completely house-bound, they might even be able to send someone to you.

Of course, as Appelbaum points out, everyone is different and some people simply need more social connection than others. You can be alone most of the time and still be happy, he says, or "you can have lots of people around you but still feel socially isolated." He says he asks patients if they have family,

friends or faith or social groups, and how often they see them, either in person or online. If someone says they see virtually no one but insists they're fine, he calls that "a yellow flag, because it correlates with mortality." He adds: "I'd probably engage members of my care team," or at least revisit the issue with the patient on their next visit.

Likewise, Greene says: "I ask people how they feel about the support around them, such as if they live with anyone. I try to ask if someone enjoys being alone, and if they say yes, then I don't try to force a lot of interaction. But I will say, '[Social connection] is also important for your health.'"



Lifestyle and behavior. Do you smoke or not? Eat mostly lean protein, fiber and whole foods or lots of fried, fatty fast or processed food? Drink alcohol? Exercise—even a brief daily walk? These all correlate with health and longevity, and they may offset some of the chronic inflammation caused by even well-controlled, undetectable HIV.

Exercise, movement and diet are especially important to prevent frailty, says Appelbaum, because "once someone becomes frail, there's not a lot you can do to reverse it." His practice can provide nutritional counseling and connection to food banks, he says. "But you have to meet people where they are." He says he tells patients that they don't necessarily have to join a gym to get in cardio and strength training, but that they can simply walk (if able) and/or do at-home chair and wall exercises.

Dr. Greene agrees. "If someone hasn't been exercising at all, they need to start slowly," she says. If you do join a low-cost gym like Planet Fitness or a nonprofit one like the local Y, they may well have low- or no-cost training sessions (at least one session is often offered free) where you can ask the trainer to help you design a fitness plan that's right for older folks, newbies or both.



Take small steps. It's important to remember that in areas such as lifestyle and social connection, you don't have to fix everything all at once. With diet, for example, "If a patient tells me they're eating fried chicken three times a week," says Appelbaum, "I'll ask if they can

cut it back to once a week, or replace French fries with a salad or vegetables."



It's OK to be a little pushy. If your provider pooch-poochs any of these issues when you bring them up ("Oh, we all get lonely sometimes," or "Well, your colonoscopy was good so we don't have to independently screen you for anal precancer or cancer"—not!), it's okay to push back and say, "Research shows this is important and I want you to help me with this or connect me to someone who can." If they refuse? You might want to talk to the clinic manager (if it's not your provider) or even look elsewhere in your area for another primary provider.

If you're in a rural area or another location where health care is sparse, your options for an HIV specialist may be limited, and you may have to get the best care possible from your existing provider.

Dr. Appelbaum sums it up like this: "For many folks aging with HIV, the HIV itself is not the major health issue—it's other conditions. People need to be aware and proactive in getting the best [care and resources] they can to prolong not just their lifespan but their healthspan"—by which he means how long someone lives with health good enough to enjoy life.

That's the path that Phillips is on. In addition to having those key conversations and tests with his provider, he says he walks eight to 10 miles a day (he's a New Yorker, after all), does yoga three to four times a week and eats high-protein, high-fiber meals like soy chorizo, chopped kale and egg whites for breakfast.

He also says that he's never smoked and rarely drinks alcohol. "I'm on a gay cruise right now and I've had one drink so far, while half the queens here are on the all-you-can-drink package," he laughs. He's on the cruise with someone he's been seeing for nearly a year but says he has lots of other social outlets, such as friends going back to third grade (all of whom know he is living with HIV, he says) and SAGEPositive, the group for seniors living with HIV from the LGBTQ seniors advocacy organization SAGE.

"I feel that I'm approaching aging with HIV from a very empowered place," he says. His advice to others? "Rather than worry," he says, "understand what changes are potentially ahead for you, be alert for them and understand how you can get ahead of them in order to counteract them." **PA**

A new once-daily pill could simplify treatment for people with drug resistance

ARTISTRY study results find that a bicitgravir and lenacapavir single-tablet regimen could simplify treatment for people with HIV on complex regimens

BY LARRY BUHL

Most people living with HIV across the world take a single-pill regimen for treatment. Others are on complex regimens because their virus has developed resistance to simpler combos or they have difficulty tolerating the drugs. In many cases, individuals were diagnosed with HIV decades ago, and many suffer a high pill burden; they may also be at risk of drug interactions due to the boosted protease inhibitors they take.

Globally, **at least 10% of adults with HIV—and up to 20% of highly treatment-experienced adults—have developed resistance to common antiretroviral drugs,** according to the World Health Organization.

This subset of people with HIV (PWH) was the focus of research on a new once-daily drug combination

of bicitgravir + lenacapavir (BIC/LEN) presented at the Conference on Retroviruses and Opportunistic Infections (CROI) in February. Results from two studies, presenters said, promise relief from the struggle with drug resistance and complex, multi-tablet regimens, even for older, heavily treatment-experienced PWH.

Presenting results from the open-label ARTISTRY-1 trial, Chloe Orkin, MBBCH, MSc, a professor at Queen Mary University of London, said that the target population for this research is virally suppressed people who may have been diagnosed with HIV decades ago, and who have a high pill burden and risk drug interactions. “This is a clear unmet need, and a novel drug such as BIC/LEN could optimize treatment for individuals with viral suppression who are on these complex regimens,” she said.

The single-tablet regimen of BIC/LEN being tested by Gilead Sciences consists of 75 mg of bicitgravir, an oral integrase inhibitor used in the Biktarvy combination pill (bicitgravir/tenofovir

alafenamide/emtricitabine), plus 50 mg of lenacapavir, the first of its class HIV capsid inhibitor. A twice-yearly injectable formulation of lenacapavir is already approved as a component of combination treatment for multidrug-resistant HIV (brand name Sunlenca) and for PrEP (Yeztugo).

In sharing top line results of phase 3 of ARTISTRY-1, which were simultaneously published in *The Lancet*, Dr. Orkin emphasized that the study population was older than that of most HIV trials, with a median age of 60 years—three-quarters of participants were older than age 55.

Results from phase 2 of ARTISTRY-1, which evaluated bicitgravir and

lenacapavir as separate pills, were presented at the 2024 International AIDS Conference, and showed that 90% of people with viral suppression who switched to bicitegravir + lenacapavir, taken as separate pills, had a viral load below 50 copies at 48 weeks, similar to participants who remained on their current regimen.

Phase 3 of ARTISTRY-1, which tested BIC/LEN as a single tablet, concluded that the BIC/LEN combination was just as effective as Biktarvy with no treatment-emergent resistance observed in most cases.

Digging into the phase 3 details, 20% of participants were women, 69% were white, 22% Latino, 17% Black and 5% were Asian. Co-existing conditions included elevated blood lipids (68%), high blood pressure (50%), high blood sugar or diabetes (24%) and chronic kidney disease (14%), with more than half experiencing at least two comorbidities. The pill burden was high: nearly two-thirds of participants were on two or more meds in addition to ART. Median CD4 cell count was greater than 600. Two-thirds had a history of AIDS.

Participants had been on antiretroviral therapy for a median of 28 years, and most were on complex HIV regimens, including 41% taking two pills a day, 26% taking three pills a day and 22% taking five or more daily. Three-quarters were on boosted protease inhibitors and most used a protease inhibitor along with an integrase inhibitor.

The vast majority were taking complex regimens due to drug resistance (81%). Others took multiple pills due to drug intolerance (23%) or contraindications (6%) to single-tablet regimens. There was a large amount of resistance to the HIV drugs nucleoside reverse transcriptase inhibitors (NRTIs; 67%), non-nucleoside reverse transcriptase inhibitors (NNRTIs;

55%) or protease inhibitors (41%). However, only 5% had resistance to integrase inhibitors (INSTIs).

"There was significant historical resistance among all of these regimens," Dr. Orkin said.

At 48 weeks, 96.0% of participants on single-tablet BIC/LEN had an undetectable viral load, compared with 93.5% of those remaining on their regimens.

Three people (0.8%) in the BIC/LEN group and two (1.1%) in the complex-regimen group had a viral load above 50 copies. No treatment-emergent resistance to the study drugs was observed. CD4 counts remained stable in both arms over the 48 weeks of treatment.

BIC/LEN was generally safe and well tolerated. The rate of adverse events was similar in both groups, however people assigned to BIC/LEN were more likely to experience drug-related events (14.3% versus 1.6%). This was to be expected, as side effects are more common in people starting new medications, Orkin said. Two people taking BIC/LEN had grade 3 or higher drug-related adverse events, predominantly upper respiratory related or headache. In all, only six people in the BIC/LEN group, and one on the complex regimen, discontinued treatment due to adverse events. There were five deaths in the BIC/LEN group, but these were considered unrelated to treatment.

Especially important for this group, there were no treatment-emergent resistant mutations in the group taking BIC/LEN. While there have been rare cases of resistance to LEN in other trials, data from ARTISTRY studies suggest a high barrier to resistance for this combination. Even when resistance does occur with LEN, it often leads to a "less fit" virus with significant replication defects, making it harder for the virus to survive.

Dr. Orkin shared good news for people with high cholesterol and triglycerides: participants on BIC/LEN saw decreases in LDL, triglycerides and total cholesterol, likely due to stopping their protease inhibitors, although HDL ("good cholesterol") was unchanged. She said that research on other metabolic changes is ongoing.

People in both groups had similar satisfaction scores, but participants who switched from a complex regimen to BIC/LEN reported increased satisfaction with the new treatment.

"These data suggest that the BIC/LEN single-tablet regimen is an important option, enabling treatment to be tailored for people with viral suppression on complex regimens," Dr. Orkin concluded.

BIC/LEN just as effective as Biktarvy in younger people with HIV

In a poster session at CROI 2026, researchers shared results from the ARTISTRY-2 trial, which evaluated the BIC/LEN single-tablet regimen as a potential option for people currently on Biktarvy.

Researchers randomly assigned 574 virally suppressed people with HIV, all taking Biktarvy, to either switch to BIC/LEN or stay on their current treatment. There were several differences between the two ARTISTRY trials: Unlike ARTISTRY-1, ARTISTRY-2 was double-blind—neither the research team nor the study participants knew who was getting what. The study population was younger in ARTISTRY-2, with a median age of 49 years and one-third being age 55 or older. Similar to ARTISTRY-1, 20% were women, but ARTISTRY-2 had more racial diversity (54% white, 27% Black, 27% Latino and 13% Asian). And while the population of ARTISTRY-1 was generally healthier, participants still had health

issues, including elevated blood lipids (41%), high blood pressure (36%), high blood sugar or diabetes (17%) and chronic kidney disease (6%).

As with ARTISTRY-1, the single BIC/LEN tablet was found to be non-inferior to participants' current regimens. **At 48 weeks, 93.5% of people in the BIC/LEN arm had an undetectable viral load, versus 90.6% for those remaining on Biktarvy, and CD4 counts remained stable in both groups.** Only five people (1.3%) in the BIC/LEN group and two (1.0%) in the Biktarvy group had a viral load above 50 copies per mL. One person in the BIC/LEN arm, who had previously taken integrase inhibitors, was found to have an integrase resistance mutation.

BIC/LEN was found safe and generally well tolerated, with the likelihood of drug-related adverse events similar in both Biktarvy and BIC/LEN arms (10.4% and 12.0%, respectively). Six people in the BIC/LEN group and three in the Biktarvy group discontinued treatment due to adverse events.

Researchers concluded that the results are "consistent with those of ARTISTRY-1 and support the use of a novel BIC/LEN single-tablet regimen to expand treatment options for people with HIV with virologic suppression [undetectable viral load]."

On NPR's *All Things Considered*, Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), director of the Desmond Tutu HIV Centre at the Institute of Infectious Disease and Molecular Medicine, University of Cape Town, said that both ARTISTRY-1 and ARTISTRY-2, as well as similar research, are crucial for staying ahead of HIV's tendency to mutate and develop resistance.

The drugmaker, Gilead Sciences, says it will use ARTISTRY-1 and ARTISTRY-2 results to file for FDA approval this year, with a possible rollout of BIC/LEN in the second half of 2026.

Reshaping children's HIV treatment

Pediatric HIV care evolves as studies explore remission, injectables and simplified regimens

BY LARRY BUHL

Across the world, an estimated 1.4 million children under the age of 14 are living with HIV. And despite advances in treatment and care, children on antiretroviral treatment (ART) have lower rates of viral suppression than adults, with less than half achieving sustained suppression, mainly due to the difficulty of adherence. Data presented at the 33rd Conference on Retroviruses and Opportunistic Infections (CROI 2026) in Denver offered the promise of addressing adherence and viral suppression in children and adolescents, through long-acting injectable ART and even therapy to control HIV without ART.

Some children stay undetectable after stopping ART

One-third of children with HIV who received very early ART had no detectable virus in their body for at least 12 weeks after stopping treatment, according to findings from a small South African study shared at CROI. The results suggest that children initiating HIV treatment at a very early age may later be able to control the virus without therapy, according to presenting author Gabriela Cromhout, MBChB, MSc, a physician and HIV cure researcher at the University of KwaZulu-Natal.

Data presented by Cromhout were inspired by a larger, earlier study. Intrigued by the Mississippi Baby case, where a child's HIV viral load remained undetectable for more than two years without ART, Cromhout's team hypothesized that very early ART initiation might limit latent reservoir formation and increase the chance for ART-free remission in some children. To test this theory, researchers established the Ucwningo Lwabantwana Cohort study

in KwaZulu-Natal, South Africa, enrolling 330 mother-infant pairs who were living with HIV. All children began receiving ART within three weeks of birth.

"The aim was to define mechanisms contributing to undetectable HIV, DNA loads and ART-free remission or cure," Cromhout said. Those results, published in 2024, found that, among children who had discontinued treatment, five boys maintained undetectable viral loads without ART.

Intrigued by the findings, Cromhout and colleagues developed another study, which they named Azaphile, purposely stopping ART in children to see whether they experienced viral rebound.

The Azaphile study was small: Researchers monitored 19 children (47% were boys, with a median age of 59 months) who started ART within 21 days of birth (median of 10 days) but stopped at less than three years old. To qualify for treatment interruption, children had to be older than 3 years, have a plasma viral load below 30 copies/mL for at least 2 years, CD4 counts above 500 (for those over five years) or

above 750 (for children 36–59 months). To participate, children also needed low DNA viral loads (below 20 copies per million).

Of the 19 enrolled, six children (32%) maintained undetectable viral loads for at least 12 weeks. Thirteen children rebounded within six weeks, however. Of the six children who stayed undetectable for 12 weeks, three rebounded, at 4, 8, 18 and 24 months after treatment interruption. The other three remained suppressed through the study.

Cromhout put Azaphile study results in the context of adult viral rebound studies, where 96% of adults experience viral rebound before 12 weeks of treatment interruption. "Which makes the fact that 32% of participants achieving [no viremia] for more than 12 weeks in our study all the more notable," Cromhout said. She concluded by saying that the results show that, **while children have a greater potential to be cured of HIV than adults, it is not entirely clear why.**

One possible reason: children's viral reservoir, which is what makes HIV so challenging to cure in adults, is very small. Cromhout said this small reservoir, in addition to early ART introduction, may help children's immune systems fight off opportunistic infections. It is also not clear whether any of the children would have remained undetectable without early ART.

"Based on adult and non-human primate studies," Cromhout added, "we hypothesize that greater numbers of very early treated children would achieve remission following bNAb (broadly neutralizing antibodies) interventions, and this is

something we are hoping to do in the future."

Controlling HIV using combination bNAbs, without ART, in children

Results from one study, presented in the same CROI 2026 session, did test how bNAbs boost viral control for children. bNAbs, specialized proteins that are either generated by the immune system, or developed in labs, neutralize highly-mutating viruses like HIV-1 and SARS CoV-2 by targeting unchanging regions of the virus and thus blocking infection and reducing viral loads.

Two presenters shared results from the IMPAACT 2042/Tatelo Plus study study, which is exploring long-acting treatment options for children living with HIV and for strategies for boosting viral control, with or without ART.

Phase 1 results of the study showed that, without phenotypic pre-screening, 44% of children who started ART soon after birth maintained low HIV RNA (fewer than 40 copies/mL) through 24 weeks while receiving bNAbs added to ART.

In the current IMPAACT 2042/Tatelo Plus study, researchers are evaluating, in four steps, whether more children can maintain higher viral suppression by pre-screening them for bNAb susceptibility or biomarkers for HIV replication, and by using broader and more potent bNAbs—without ART. Eligibility criteria included children with HIV RNA fewer than 40 copies per mL for at least 24 weeks prior to entry into the study. Participants had a median age of nine years and all had initiated ART within five days after birth.

Results of step one, presented in two posters (839, 840), indicated that infusions of PGDM1400LS, PGT121.414.LS and VRC07-523LS were safe and well-tolerated in children with HIV in Botswana who were treated early, using phenotypic susceptibility testing. Researchers found that six (75%) of eight participants were either fully or partly susceptible to at least two bNABs, which allowed them entry to the next study phase.

In step two, participants were susceptible to at least two of the three bNABs stopped ART and continued to receive bNABs only. In presenting findings from children who completed the bNAB-only treatment, Gbolahan Ajibola, MB, BS, MPH, MSc, from the Botswana Harvard AIDS Partnership, said all participants had excellent viral suppression at the time of entry to the bNAB-only step. All participants stopped ART and completed the full 24 weeks of bNAB-only treatment without missed doses. There were no grade three or four adverse events. Importantly, bNAB-only treatment did not result in virological failure.

"We're happy to report that HIV RNA remained below 40 copies/mL in all participants throughout the entire 24 weeks period," Ajibola said.

In step three, which is ongoing, researchers will perform analytic treatment interruption to evaluate viral control without ART or bNABs. In step four, ART will be restarted and researchers will evaluate long-term safety, including development of bNAB resistance and anti-drug antibodies to bNABs.

Ajibola noted some limitations of the study. Participants were selected based on early ART initiation and other favorable characteristics, which may not be generalizable to other children with HIV. Also, the bNAB-only treatment used a non-randomized design, and

because of that, "it is possible that some of these children may control the virus without the need for bNABs," Ajibola said.

In conclusion, Ajibola said, **"a combined approach using phenotypic screening and biomarker criteria offers a practical first step for trials of bNABs to promote drug-free [HIV] remission in children."**

DTG/3TC could reduce pill burden for children

While adults have recently benefited from two-drug treatments, evidence for efficacy of simpler regimens for kids has been slow to come. And with everyone, but especially with children, fewer pills can increase all-important adherence.

The D3/Penta 21 trial enrolled 386 children and adolescents across Uganda, South Africa, Thailand, Spain and the U.K. to make sure the regimen was safe and simpler, but equally effective. Anna Turkova, MD, chief investigator for D3/Penta 21, presented week 96 results of the non-inferiority trial of two-drug regimen dolutegravir/lamivudine (DTG/3TC). The conclusion: DTG/3TC is just as effective as the standard three-drug therapy at keeping the virus suppressed, as well as being slightly more favored by kids.

Participants, all virologically suppressed for at least six months with a median age of 8.3 years, were stratified by age groups—2–6 years, 6–12 and 12–15—and randomized into two arms. The first arm was DTG/3TC, and the second arm was DTG plus 2 NRTIs. The smallest children were given dispersible tablets; bigger kids had either dispersible tablets or adult film-coated tablets.

The safety profile and tolerability were similar in both arms. In rare cases where virus levels rose slightly, most children in both arms returned to suppressed levels by the end of two years. Few children switched regimens:

seven (4%) in the DTG/3TC arm switched to three-drug regimens, and 14 (7%) in the DTG/3DR arm switched to the two-drug regimen.

Satisfaction with treatment was high in both arms though slightly higher in the DTG/3TC arm. **Besides reducing the pill burden, transitioning virologically suppressed children to DTG/3TC can save money, around \$145 per child per year.** "Children who are virologically suppressed on their first-line treatments can safely be switched to DTG/3TC," Turkova said.

End of study results showed that CAB + RPV given every two months maintained viral suppression (94.4%) with no confirmed virologic failures. At all weeks evaluated, greater than 97% preferred long-acting injections over daily oral antiretroviral therapy. For those who completed all 96 weeks, all (100%) preferred injections over daily oral therapy.

The long-acting regimen was well tolerated, with 42% experiencing drug-related adverse events (AE), the most common of which were cough (31.9%), headache



Adolescents with HIV overwhelmingly choose injectable ART

Also at CROI 2026, ViiV Healthcare shared 96-week results from the 2017 IMPAACT (MOCHA) study, which, in addition to showing that long-acting Cabenuva (cabotegravir/rilpivirine) maintained very high viral suppression among youth ages 12–18 years, that 100% favored this treatment over oral ART by the end of the study.

Results showed **94.4% of virologically suppressed adolescents ages 12–18 years who switched from daily oral HIV treatment to Cabenuva every two months maintained viral suppression at week 96, with no confirmed virologic failures.**

(26.4%) and upper respiratory tract infections (20.1%). Of 142 participants having received at least one injection, 37% reported mild to moderate injection site pain that typically resolved within one week.

Presenting the results, Aditya Gaur, MD, a doctor at St. Jude Children's Research Hospital and co-lead investigator of IMPAACT 2017 (MOCHA) said that the majority of this cohort has lived their life knowing HIV. "This was the first opportunity they had to stop their oral medications and take and go on to injections," Gaur said. Moving to a brief clinic visits every two months can help reduce the daily reminder of HIV, he added.

How routine, opt-out screening led to 100% linkage to care at one FQHC network

From testing to treatment: Opt-out model improves HIV outcomes in high-need settings

BY LARRY BUHL



Despite advances in HIV prevention, underserved patient populations face disproportionate HIV rates and poorer health outcomes due to poverty, lack of access to healthcare, stigma and discrimination. In an oral abstract presentation at CROI 2026, Timothy Long, MD, chief clinical officer at Health Choice Network, a federally qualified community health center (FQHC), shared data from a study exploring how routine, opt-out HIV screening improved testing numbers for this population, and, importantly, linkage to care for people testing positive. The bottom line: interventions significantly boosted the number of people tested and successfully linked everyone diagnosed to care.

The observational cohort study, sponsored by Gilead Sciences, covered data from 2021–2024, collecting data from 13 FQHCs with the highest need and the highest positive rates, to assess the impact of the drugmaker's FOCUS model, a public health initiative enabling partners to develop and share best practices in screening, diagnosis and linkage to care for HIV and hepatitis B and C.

The study covered four years, starting in the Miami-Dade area and expanding to 13 FQHCs including centers in New Mexico, Florida and Puerto Rico. These centers received FOCUS interventions, including not only routine testing, but better language services, help with payment and even mobile outreach for harder-to-reach

people. Data on demographics, screening utilization and linkage outcome data were analyzed using multivariable logistic regression to determine which practices led to the greatest success.

Over that time 216,000 patients were screened using opt-out testing, which was something many providers in this network were initially apprehensive to do, Dr. Long said. With opt-out testing, people are automatically tested unless they specifically refuse the test. During that period, researchers identified 1,948 new cases of HIV, as well as 1,667 people who had already tested positive for HIV but were not engaged in care.

"All 100% of those that had a positive diagnosis were then linked into care or re-linked into care within one

of our community health centers; 90% of them were linked within that first 30 days," he said. "Getting people linked to care quickly was a challenge, because many of our patients were experiencing homelessness."

But Dr. Long said some facilities had mobile clinics that met this population. **A persistent and invested case management team going out on the street and offering ride shares was key to boosting not only testing but linkage to care,** he added.

Payment was another hurdle: many FQHCs serve uninsured patients, up to 60% across Health Choice Network, while the rest are served by Medicaid and Medicare and, to a small degree, private insurance, according to Dr. Long.

Language was identified as a potential barrier to overcome. "Because we're in South Florida, we did see a lot of Creole-speaking patients, and they had a higher predictive value to get tested," he said. "And so many of the health centers that treat Creole-speaking patients have to have staff that create language-appropriate materials to help with those patients. The biggest cultural shift within the FQHC network, which took several years to overcome, was the move from risk-based testing to universal

opt-out testing. But that shift had the biggest impact in the success of the study," he said.

The initial conversation, usually by phone, if possible, is key to linking people to care. "I hired [a coordinator] who is empathetic and **it's the tone—that we'll take care of you—in that initial conversation, that allows the linkage and the provider to have a more in-depth conversation.**"

Dr. Long noted that not all of these health centers had Ryan White funding, so it was important to get patients with HIV into regular primary care, but not necessarily linked to an infectious disease specialist—a hand-off which could add time to the process—so that people testing positive could start treatment within a few days. Practices and processes were shared across the 13 centers, he said, so that clinical prompts and clinical decision support were uniform throughout the wider network. Beyond Health Choice Network, the model is scalable and offers a blueprint for all clinics to advance Ending the Epidemic (EHE) goals, he said.

"Now in year six, we're looking for other ways to expand this work to all of our 90-plus centers across the country [in addition to] Puerto Rico," Dr. Long concluded.

The state of PrEP worldwide and new strategies for uptake

Funding cuts stall PrEP progress even as new options show high effectiveness

BY LARRY BUHL



Encouraging and disappointing news was presented on HIV prevention with PrEP at CROI 2026. The disappointing news was evidence that PrEP use is not coming close to meeting demand, and in resource-poor countries is backsliding. More favorable news came from studies showing that when vulnerable populations have easy access to PrEP—not a given in the current climate—HIV acquisition rates drop substantially. Several presenters shared data on novel ways of reaching different groups of people with the assumption, of course, that funding for outreach is available.

Funding cuts decimated PrEP uptake worldwide

Even before President Donald Trump issued executive orders last year that slashed many foreign-assistance programs, use of PrEP, especially in developing and resource-poor countries that depend on such aid, was seriously lagging. In the past year, PrEP use in many parts of the world has fallen off a cliff, according to Andrew Hill, PhD, of Liverpool University in the UK. At CROI 2026, Hill

shared data showing that **U.S. funding cuts reduced the number of people on PrEP by as much as 98% in some countries since 2024.** He added an urgent warning: if funding is not restored, not only would the UNAIDS target of no more than 370,000 new cases of HIV a year not be met, there could be more than 1.4 million HIV acquisitions per year worldwide.

Even the most effective methods of HIV prevention available today—injectable PrEP—has to reach a lot of

people to have a significant effect on reducing HIV cases. That would require affordable mass distribution, he said, which is not happening.

“PrEP is having little or no impact on HIV incidence in low- and middle-income countries,” Hill said.

He added that **long-acting injectable PrEP, which could address adherence issues, though it is still cost-prohibitive in most countries, could be a game changer worldwide.** He referred to two studies—PURPOSE 1 in African cisgender women and PURPOSE 2 in men who have sex with men (MSM) and trans people worldwide—to estimate the effect of injectable lenacapavir for PrEP (LEN) on the overall population. Hill said that, based on data from these two studies, LEN prevented one HIV acquisition for every 42 people who would otherwise have acquired HIV over the course of a year.

But few countries are achieving this rate of PrEP

coverage, through oral or injectable: only Australia, Denmark and Norway are currently preventing at least one acquisition per 42 people, with the UK preventing an estimated acquisition per 40 people. African countries have fared the worst, even before PEPFAR cuts: In South Africa, for example, there was only one person on PrEP for every five new acquisitions before the cuts. In Zambia, the rate was one person on PrEP for every 14. After the U.S. global aid cuts, there are 28% fewer PrEP users in South Africa, despite governmental funding, and 58% fewer users in Zambia. In other countries PrEP use has gone from minimal to negligible. PrEP use in Uganda has fallen by 70%, Malawi by 75% and in Nigeria by 98%. By the raw numbers, Nigeria has gone from nearly 400,000 PrEP users in 2024 to only 7,000 in a year.

It isn't just PEPFAR cuts causing a drop in PrEP coverage, Hill pointed out. PrEP usage in Brazil,

which hadn't received U.S. funding, fell from approximately 170,000 to 101,000 between December 2024 and December 2025. India's PrEP coverage still hasn't gotten off the ground, with only 2,100 people using PrEP in the whole country, translating to approximately two users for every 100 HIV acquisitions. If these trends don't reverse, Hill reported, global HIV infections in 2030—the target for Ending the Epidemic goals—will remain at 2022 levels.

Hill proposed several possible solutions, each with their own difficulties, without the restoration of U.S. funding (and that restoration is unlikely during the Trump administration). These funding workarounds, all with their own difficulties, including restricting PrEP to people who are most vulnerable in developing countries, such as sex workers, and making PrEP as cheaply as possible, utilizing generics.

Right now, **wider use of generics has the most promise**: tenofovir is available in the U.S. at \$35 per person per year. As for long-acting injectable PrEP, drugmaker ViiV Healthcare has agreed to license generic long-acting cabotegravir (CAB) for \$180 a year in 90 countries, while Gilead has signed non-exclusive, royalty-free licensing agreements with six generic manufacturers to produce and supply lenacapavir for 120 lower-income countries. Last year Hill presented findings showing that the drug could be manufactured for about the same price as oral PrEP and still turn a profit for the company, provided that PrEP use scales up substantially. In addition to these methods, Hill recommended an HIV Protection Fund of \$500 million a year, which he estimated would jump start the use of long-acting lenacapavir in low- and middle-income countries.

"We have achieved high coverage of ART [antiretroviral therapy] worldwide," Hill

said. "Now we need to do the same for PrEP."

New data show lenacapavir for PrEP highly effective and well-tolerated

Other presentations at CROI 2026 shared new longer-term data on long-acting PrEP in various populations, adding to the growing amount of evidence that injectable PrEP is highly effective at preventing HIV, provided that people can access it.

Nkosiphile Ndlovu, MBChB, senior research clinician at Wits Reproductive Health and HIV Institute in South Africa, presented longer-term safety and efficacy data on twice-yearly subcutaneous lenacapavir (LEN) through the end of the randomized blinded phase of PURPOSE 1. LEN efficacy remained high for the trial's population, young cisgender women, through the end of the randomized blinded phase, with 77 new HIV acquisitions in both oral PrEP arms, compared to only two new acquisitions in the LEN group. Ndlovu did not say, but it was speculated that the efficacy of LEN versus oral PrEP was due to adherence issues.

LEN was also shown to be well-tolerated, with no new discontinuations due to side effects.

Dr. Ndlovu emphasized the need for long-acting PrEP in young cisgender women, noting that, **globally, nearly half of all new HIV cases in 2024 were among girls and women**. In sub-Saharan Africa, girls and women accounted for nearly two-thirds of new HIV acquisitions. "These findings position twice-yearly subcutaneous LEN as a powerful, durable, low-burden HIV prevention option for one of the populations most urgently needing innovation," she said.

In the same session at CROI 2026, longer-term follow-up data were presented from the end of the randomized PURPOSE 2

trial. Valeria Cantos Lucio, MD, a physician at Emory University in Atlanta, shared data from PURPOSE 2, an ongoing phase three clinical trial where participants, cisgender men and gender diverse people who have sex with men, were randomized to two groups receiving either subcutaneous LEN every 26 weeks or oral medication (the generic version of Truvada, emtricitabine plus tenofovir DF, or F/TDF). The longer-term data closely resemble earlier findings, with LEN remaining highly efficacious through the end of the randomized blinded phase, Dr. Lucio said. "Since the primary analysis, one new HIV acquisition occurred in the lenacapavir group for an overall total of three, and three new HIV acquisitions occurred in the F/TDF group for an overall total of 12," she said. "This yields an HIV incidence rate of 0.11 per 100 person year in LEN group, and 0.92 per 100 person year in the F/TDF group."

As with the PURPOSE 1 results, there were no new discontinuations due to side effects.

PrEP for postpartum women: more choices equal better adherence

Another presentation at CROI 2026 emphasized the need for more choices in how cisgender women get PrEP. The "dynamic choice" HIV prevention model, which allows people to choose and switch between daily oral PrEP, post-exposure prophylaxis (PEP) and long-acting cabotegravir (CAB), has gotten attention in recent years. But there's also a dynamic choice model for delivering PrEP as well, and it appears that many postpartum women appreciate the option of having fewer steps (no counseling needed) in getting PrEP.

Dvora L. Joseph Davey, MPH, PhD, a professor at the University of California–Los



Angeles, shared results of a study on **dynamic choice, also called dynamic service delivery or DSD, in PrEP delivery and HIV testing for postpartum women. When offered the choice of rapid clinic pick-up of PrEP (and a choice in HIV testing), most women chose this option, and half switched their method of collecting PrEP**. The study enrolled 266 women (132 in the dynamic choice arm and 134 in the counseling arm) who had discontinued PrEP or had poor adherence for more than three months while pregnant. Participants were mostly young—median age of 25—unmarried and sexually active.

In the dynamic choice arm, 49% preferred rapid clinic pick-up of PrEP, versus 46% preferring home delivery and 7% choosing community pick-up. For HIV testing, 57% chose clinic-based rapid testing while 43% chose self-testing. Researchers found that dynamic choice improved PrEP continuation and adherence compared to biofeedback PrEP counseling,



(58% continuation and adherence, versus 42% continuation and adherence, respectively) in the first three months. Overall, nearly half (45%) in the dynamic choice arm were PrEP adherent by the study's endpoint.

“Dynamic choice in PrEP delivery increased the odds of PrEP persistence, highlighting the need for choice in PrEP delivery and modalities,” Dr. Davey said.

French study: Better PrEP outreach needed among foreign-born populations

Following up on the results from its first three years, published in 2022, the final results of a large French study that offered a choice of daily or event-driven (on-demand) oral PrEP were presented at CROI.

The Prévenir Study, which ended in May 2025, enrolled over 3,200 people, most of them cisgender men who have sex with men (MSM), at 26 sites in the Paris region. Final results showed that both daily and on-demand oral PrEP (tenofovir

disoproxil/emtricitabine) were safe and effective, according to presenter Jean-Michel Molina, MD, MPH, professor of Infectious Diseases at the University of Paris Cité and head of the Infectious Diseases Department at the Saint-Louis and Lariboisière Hospitals in Paris.

“Enrolling mostly MSM, born in France, we had a very low HIV incidence, which was sustained over the eight years of follow up, a good safety profile with on-demand PrEP... and a significant reduction in Paris during the time of the study of HIV diagnosis among MSM born in France,” Dr. Molina said.

But it was a different story for MSMs not born in France, many who came from Africa, and accounted for nearly one in six participants (17.5%). **For the French-born majority, HIV cases fell by a third, but for participants born abroad, HIV acquisition increased by 73%, resulting in no significant change in HIV diagnoses among study participants,** overall. These results led him to conclude

that better outreach and PrEP education is needed to inform and protect vulnerable populations, including immigrants.

Even with the high rate of new HIV cases among foreign-born Parisians, the overall annual HIV incidence for all study participants was very low: only 14 participants acquired HIV, for a rate of 0.11% annually. HIV incidence was double for people who primarily used PrEP on demand, but because there were so few HIV acquisitions, the difference was not statistically significant, he said. Nine of the 13 who acquired HIV were not taking PrEP, and the other four showed evidence of suboptimal adherence. People were likelier to switch to on-demand PrEP when they were having less sex, and on-demand users tended to be older.

Throughout the study, half of the participants were taking daily PrEP and half event-driven or on demand. However, participants were likely to switch between daily and on-demand, based on their lifestyle and perceived risk: nearly two-thirds of participants who started on daily PrEP changed to on-demand at least once; slightly more than half changed at least once from on-demand to daily.

One disappointment: a goal of the Prévenir study, to lead to a 15% population reduction in HIV cases in the Paris region over eight years, was not met, he said. Population-level HIV incidence only fell by 2% during that time, even though the overall number of PrEP users in the region increased from a few hundred to more than 27,000.

Digging into study details, nearly all (99%) of Prévenir participants were MSM, 85% were white, and the average age was 36. Only a few participants (27) were heterosexual women or men and 14

were transgender women. Most (60%) had previously used PrEP.

Participants were divided into three arms: those who spent more than three-quarters of the study period on daily PrEP (38%), those who spent more than three-quarters of the time using on-demand PrEP (38%) and those who switched back and forth (23%). As to be expected with such a long study, of the many participants who dropped out, 66% of on-demand users, 60.5% of daily users, and 56% of switchers left the study. Other findings:

- Only a small percentage of discontinuations were due to side effects, and the only significant drug-related adverse events were gastrointestinal (experienced by 4.5% of on-demand users, and much less by daily users).
- There was a high annual incidence of gonorrhea and chlamydia (33% and 26% respectively), but a low rate of syphilis (1%).
- Hepatitis C infections were high across all arms (61 in total or an annual incidence of 0.45%), attributed mostly to IV drug use.
- The number of sexual partners decreased by 23% among daily PrEP users and by 37% in switchers over eight years.
- The proportion of people who had receptive sex without a condom rose overall from 40% to 50% over eight years.



How antibodies and T cells could keep HIV in check—without ART

It's no silver bullet, but a complex strategy that bolsters the immune system

BY LARRY BUHL

New research suggests that a combination of experimental immunotherapies could allow the body's immune system to reprogram itself and control HIV without long-term use of antiretroviral therapy (ART). Combination immunotherapy techniques, including HIV vaccination and immune stimulation through broadly neutralizing antibodies (bNABs), have shown promise in non-human primate research, but two newly published studies offer hope that these approaches could work in people, by working with parts of the immune response to control HIV.

A combination against resting virus

In a small, proof-of-concept study conducted by the University of California–San Francisco (UCSF) and released on December 1, World AIDS Day, in *Nature*, researchers enrolled 10 participants, seven of which were able to keep HIV at low levels after going off ART for a significant length of time.

All 10 had well-controlled HIV and started ART soon after they acquired the virus. For the study, all participants received a therapeutic vaccine to encourage their T cells to attack latent HIV (it's resting in parts of the body—called the viral reservoirs—but

not replicating). Then, they received an antibody combination including two bNABs. They were also given the drug lefitolimod, which activates a protein called Toll-like receptor 9, which charges innate immune responses. (Innate immune responses are the body's general, rapid-response defenses such as mucous membranes and chemical defenses like stomach acid or tears.) More long-acting bNABs were given when ART was interrupted.

When ART is stopped, HIV typically rebounds in about two weeks and then increases rapidly. But in the UCSF study, only three of the 10 patients experienced the typical rapid rebound, while six maintained low levels of the virus for months. For one participant, HIV did not rebound for the length of the study.

Researchers found that those who controlled the virus were able to do so through T cells that expanded dramatically when confronting the virus.

The most significant finding of the study was the identification of a biological response in the CD8+ T cells to the virus as it was re-emerging when ART was paused, according to Michael Peluso, MD, an assistant professor in UCSF's Department of Medicine and the study's first author. That finding gives researchers an important lead on what

future interventions should be trying to achieve, he told POSITIVELY AWARE in an email. "We think that the combination of immunotherapies played a role in inducing that response, and this study gives us something to focus on in future studies which we can try to design to try to induce that response."

Importantly, "elite controllers"—people with unique genetics that allow them to spontaneously control HIV without medication—were excluded from the study, researchers said. However, Peluso said they learned after the trial that several of the participants had certain genetic markers that have been associated with post-treatment control of HIV in some studies, but not in others. "We don't think that alone explains the findings," he told POSITIVELY AWARE.

Peluso urged optimism and caution about the results of the combination immunotherapy used in the study.

"The results are not definitive, and the approach we used in this trial is not the endgame," Peluso wrote. **"Although we believe that we moved the needle in terms of helping some participants' immune systems to have better control of HIV, this needs to be confirmed in larger studies** with placebo arms, for example through networks like the ACTG [originally the AIDS Clinical Trials Group, now known as Advancing Clinical Therapeutics Globally]."

Peluso also said that the regimen administered to the participants was very complicated and not scalable. "The regimen included 34 weeks of immunotherapy interventions and very intensive monitoring, and the level of viral control achieved although impressive is still probably not good enough. No one would think that what we achieved here is better than ART. However, we have for so long framed inducing control of



MICHAEL J. PELUSO, MD

HIV without medications as an insurmountable challenge, and this trial provides hope that that challenge can be overcome.

"Regarding your final question," he continued, "It is likely that all branches of the immune system play a role in achieving post-intervention control. We recently wrote a review on this. We think there were a variety of factors that played a role in our study—potentially some effect of the vaccine, followed by the bNabs helping to prevent the typical explosive HIV rebound, and basically preventing the virus from outrunning the immune system, and the enhancement of HIV-specific CD8+ T cell responses due to the combination of interventions. Ultimately HIV-specific CD8+ T cells seemed poised and ready to go after HIV as it was emerging, and that CD8+ T cell response was the strongest correlate of control."

bNabs before stopping ART. They compared samples from two groups: seven participants who could keep the virus at very low levels for up to seven years of bNab treatment with samples of five participants who experienced viral rebound. The team found that in the group who didn't experience viral rebound, CD8+ T cells, which they call "post-intervention controllers," effectively multiplied and killed HIV continually. Treatment with bNabs was helpful in enhancing the ability of existing CD8+ T cells to fight infection, but the team concluded that having robust HIV-targeting CD8+ T cells—cells that mimic a stem-cell state—before treatment with bNabs was key, although the bNabs appear to have enhanced existing immune responses.

"These individuals are distinguished by the quality of their pre-existing cellular immune responses against HIV, specifically the ability of their CD8+ T cells to

Adding it up

Both authors emphasized that the **results are preliminary and they don't clarify how bNabs and other therapies might charge the immune system to fight HIV.** But the studies add to a growing body of research that gives hope for an alternative to lifelong ART.

In a commentary, also published in *Nature*, Jonathan Li, MD, an associate professor at the Harvard Medical School, said that both studies point to the importance of regenerative, adaptive anti-HIV CD8+ T cell response for bNabs to be effective and that they suggest a delicate balance of viral proteins—or antigens—"sufficient to stimulate CD8+ T cell immunity but not overwhelm it, could be central to achieving post-ART HIV control."

Both studies underscore three key principles, Li wrote. "First, the quality of anti-HIV CD8+ T cells matters, especially the presence of stem-cell-like antiviral CD8+ T cells that are capable of sustained proliferation and cytotoxic responses. Second, bNabs and T cells might act in synergy, given that effective anti-HIV antibodies can delay or reduce the immediate post-ART viral rebound (or do both) and create an immune environment that is conducive to enhancing effective cellular responses. Third, therapeutic combination approaches that incorporate several branches of the immune response are likely to hold the greatest promise. Coordinated use of T cell-inducing vaccines, bNabs and other immunomodulators might reproduce the rare immune features in people who achieve post-ART HIV control."

What's in a word?

For more than three decades ART has transformed HIV from a virus that usually led to death into a chronic and manageable condition. Still, taking daily pills for life (or getting regular injections in the case of long-acting ART) can be a burden. And while ART suppresses viral replication, it doesn't completely reduce chronic inflammation, a condition that can lead to health problems like cardiovascular disease and neurocognitive disorders. That's why the HIV research community continues to search for alternatives.

There is a robust and active debate about what management of HIV without ART should be called—terms such as "long-term remission" or "functional cure." Peluso said that the most accurate term is "post-intervention control," to indicate that it was achieved after a set of interventions that go beyond standard ART. Both studies indicate that there is likely no silver bullet for this control, but rather a complex strategy to enhance the body's immune system. **PA**



DAVID COLLINS, PhD, (LEFT) AND RAGON FOUNDING DIRECTOR BRUCE WALKER, MD, (RIGHT) MEETING A RESEARCH PARTICIPANT AND ELITE CONTROLLER AT THE RAGON INSTITUTE.

An immune cell that keeps HIV in check

One other study, also published on December 1 in *Nature*, offers additional hope for an ART-free future with the finding that some people control HIV without ART after receiving bNab infusions. The study, conducted by Mass General Brigham and the Ragon Institute, concluded that some people with HIV who are given bNabs can safely stop taking ART and still maintain control of the virus for years, while others taking bNabs do not achieve remission. It offers an insight into how the body's natural defenses could be boosted to achieve long-term HIV remission, researchers say.

The team analyzed blood samples from 12 people with well-controlled HIV in four different clinical trials who received

proliferate and kill infected cells," said the study's senior author, David Collins, PhD, an investigator at the Ragon Institute of Mass General Brigham, MIT and Harvard, in an email.

Collins acknowledged that the study was small and will need to be followed up in larger trials, with placebos, to identify ways to reduce the HIV reservoir and determine optimal timing and dosing with bNabs. But he said that its results clearly show the importance of enhancing the immune system to achieve durable post-treatment control of HIV. "Building on these findings, it will be important to develop approaches to elicit these protective immune features in a larger proportion of people living with HIV to achieve a functional cure that is both scalable and effective."

Today's chemsex pandemic requires NOVEL APPROACHES

We must adopt a syndemic response to the complicated relationship between HIV and sexualized drug use

BY DAVID FAWCETT, PhD, CST, CSAT, LCSW



Luís* is a 29-year-old bilingual Latino gay man who works two service jobs, lost consistent primary care during the pandemic and now gets most sexual connections through hookup apps late at night after long shifts. Occasionally using meth in sexual settings to push through exhaustion and feel more connected, his PrEP refills lapse intermittently, condom use varies with fatigue, alcohol and stimulant effects, and testing happens only when a scare occurs—not because of a lack of knowledge, but because healthcare access never quite fits his life.

Luís represents a modern version of the chemsex phenomenon common in the men who have sex with men (MSM) community for many years. This typically involves methamphetamine use and other mood-altering substances such as GHB. It has long been associated with both the chance of HIV seroconversion as well as complications and progression once seroconversion has occurred. From the earliest days of the meth epidemic, researchers have been aware that the heightened release of dopamine and other neurochemicals could override both rational thoughts and impulse control, resulting in less condom use, poorer

decisions and higher rates of insertive anal intercourse.

The contours of the chemsex epidemic have shifted but its significance has not waned. Thirty years later, the use of meth and other drugs along with sexual behavior (now broadly termed as *sexualized drug use*), continues to complicate the HIV landscape. As with any epidemic, syndemic elements collude to heighten the impact of sexualized drug use on both the potential for acquisition and trajectory of HIV.

Surviving one epidemic only to face another

Meth and HIV have long been intertwined in a complicated relationship. Once protease inhibitors became available

in 1995, HIV mortality rates began to drop. Men who expected to die and had given up careers, racked up credit card debt and went on disability, now found themselves surviving. At the same time, methamphetamine and Viagra entered the scene. In that setting meth was the perfect drug to dissociate or check out from life's problems, replacing them with a surge of dopamine that frequently merged with distracting sexual fantasies and behaviors. More than one observer has noted the irony of surviving HIV only to succumb to chemsex.

In those days, nearly all methamphetamine was created by so-called mom-and-pop cooks who blended thousands of pseudoephedrine tablets with a variety of toxic chemicals to create homemade batches that were often distributed locally. In 2005, the Combat Methamphetamine Act restricted the sale of pseudoephedrine; nearly overnight local meth cooks were out of business. Demand remained high, however, and Mexican drug cartels, quickly realizing the opportunity, stepped in to meet demand. Production shifted from pseudoephedrine-based precursors to phenylacetone (phenyl-2-propanone, or P2P), effectively modernizing an older manufacturing process to one known as the P2P method.¹

Many researchers believe this formula change resulted in a significantly more dangerous drug. Meth produced with the P2P method has higher potency, purity and availability.² By 2010, nearly 90% of the meth sold in the United States was manufactured using this new method. Because it was cheaper and more potent there was increased market penetration, which compounded the impact of its toxicity. P2P meth isn't just more potent, it's often thought to be "dirtier" and associated with more intense psychoactive effects, including extreme persistent paranoia and hallucinations, longer lasting intoxication and higher risk of psychosis, aggression, cognitive damage and unpredictable behavior. In my own clinical experience, psychosis caused by meth in the 1990s typically would resolve within several

* "Luís" is a composite example based on multiple patients and case studies; the name does not refer to a specific individual.

‘Those of us working at the intersection of these epidemics have a responsibility to address increasingly potent substances, shifting behavioral patterns and their expanding impacts...’

days of stopping use. With P2P meth, it is not unusual for psychosis to persist. In about one-third of cases it may never resolve and can in fact lead to other serious mental disorders such as schizophrenia,³ especially in those with preexisting vulnerability to acquisition.

Because production now occurs at an industrial scale in factories just across the U.S.–Mexico border, supply is harder to disrupt, driving lower prices and greater availability. This saturation has accelerated dependence, destabilized housing and employment and placed increasing strain on healthcare, shelter and public safety systems.

These changes demand that we adapt our response to the syndemic of HIV and substance use. Those of us working at the intersection of these epidemics have a responsibility to address increasingly potent substances, shifting behavioral patterns and their expanding impacts on healthcare systems, housing stability, community safety and relational health.

Chemsex continues to drive potential acquisition through complex systems

The use of meth and other drugs in sexualized settings remains a significant factor in HIV transmission potential. Rather than limiting the focus to individualized risk, however, research indicates that network density, prolonged sexual activity, partner turnover and app-based partner finding all contribute to heightened probability of vulnerability.⁴ Much of the research has focused on specific groups and potential for seroconversion. Using demographic categories as a stand-in for complex behavioral phenomena, however, can obscure actual drivers and reinforce stereotypes. These complex relational system dynamics, not demographic descriptors, are significant. They include how isolation shapes the hunger for attachment, how minority stress and other pressures can increase compulsive reliance on soothing behaviors, how disruptions in health care systems have altered prevention continuity and how online environments have accelerated intensity and risk.

Effectively responding to chemsex is not just about messaging but rather adjusting system design and service integration. In the U.S., as has long been the case in Europe, clinics and community programs are increasingly offering chemsex-friendly services that blend sexual health, harm reduction, mental health and substance use care⁵ with peer navigators, low-threshold PrEP and initiation

of same-day services. This significantly shifts the conversation from strictly risk avoidance counseling to engagement without stigma.

HIV prevention tools shift the narrative

In the last decade we have seen powerful new HIV prevention methods, notably oral PrEP and long-acting injectable PrEP (cabotegravir and lenacapavir) which have shifted the conversation beyond condom use and toward integrating biomedical prevention into community norms and practices. For people engaged in meth-associated sexual networks, PrEP offers a pragmatic strategy where real-world adherence is often complicated.

U=U—*Undetectable = Untransmittable*—has also shifted our understanding of preventing sexual transmission with sustained viral suppression. Meth use, however, can be associated with disruptions in care, including missed doses of HIV medication, appointment nonadherence and long and frequent gaps in retention which can undermine the protective benefits of U=U.

As HIV prevention has rapidly advanced, non-HIV sexually transmitted infections, along with hepatitis C, have become more prominent in sexualized drug use networks. Importantly, doxycycline post-exposure prophylaxis (doxy PEP) is now often included in clinical guidance for individuals with a greater chance of exposure.

Sexualized drug use conceptualization and treatments have progressed

Unlike other categories of substances, stimulants had no effective pharmacotherapy despite widespread trials of many different drugs. Since 2020, evidence has strengthened around certain medication strategies such as combining extended-release naltrexone with bupropion (brand name Contrave).⁶ This, when combined with behavioral interventions, can support people managing substance use that may affect HIV care.

The terminology used to describe sexualized drug use, especially the term “chemsex,” has evolved to more accurately describe specific patterns and context of behavior, not just any use of drugs and sex. *Chemsex* has long been utilized to describe sexualized drug use involving stimulants and other substances among MSM. More nuanced discussions importantly now look at the type of drug (such as meth vs. GHB/GBL vs. mephedrone), the route of ingesting (e.g., smoking,

as opposed to injecting), who is using the drugs and the duration of context (length of sessions, negotiated boundaries, etc.). Such precision improves both research quality and clinical screening.

It is also noteworthy that sexualized drug use has spread beyond the MSM community and is increasingly seen among heterosexual males and females. The potential acquisition of HIV and other STIs, consequently, is increasing among those populations who have traditionally had fewer HIV-related conversations about acquisition.

A call to action

The seemingly unending epidemic has evolved, and our response must evolve as well, incorporating status-neutral HIV care; integrated sexual health, substance use and mental health services; and non-stigmatizing harm reduction and evidence-based interventions grounded in real-world lived experience. **PA**

DAVID FAWCETT, PHD, CST, CSAT, LCSW, is a psychotherapist and sex therapist specializing in sexualized drug use, LGBTQ+ issues, trauma and mental health concerns related to physical illness, especially HIV/AIDS. He co-created the residential treatment program for compulsive sex, porn and chemsex behavior at Seeking Integrity in Los Angeles. He presents workshops globally about addiction and co-occurring mental health issues, particularly those related to long-term survivors of HIV. He is the author of two books, *Lust, Men and Meth: A Gay Man's Guide to Sex and Recovery* and *Sex Under the Influence: Understanding and Healing from Sexualized Drug Use*. Learn more at david-fawcett.com or follow him on TikTok, [@davidfawcettchemsex](https://www.tiktok.com/@davidfawcettchemsex).

REFERENCES

- 1 Maxwell, J.C. (2011). Methamphetamine Here we go again. *Frontiers in Psychiatry*.
- 2 Drug Enforcement Administration. (2024). Mexican cartels produce synthetic drugs including methamphetamine. National drug threat assessment.
- 3 Glasner-Edwards, S., Mooney, L.J. (2014). Methamphetamine psychosis: Epidemiology and management. *Journal of Dual Diagnosis*.
- 4 Centers for Disease Control and Prevention. (2021). HIV and gay and bisexual men. U.S. Department of Health and Human Services.
- 5 Rodriguez-Espinoza, B., et al. (2024). Psychological characteristics associated with chemsex behavior. *European Psychiatry*.
- 6 Trivedi, M. H., Walker, R., Ling, W., et al. (2021). Bupropion and naltrexone in methamphetamine use disorder. *New England Journal of Medicine*, 384(2), 140–153.



BEING BRIDGETTE

Bridgette Picou

Community and clinicians meet

The pre-CROI Cure Research Community Workshop is a common ground for researchers and community

There was a time when someone mentioned science to me that my first thought was of dissecting frogs, lab beakers and making a paper-mache volcano explode. These days its viral life cycles, medication modalities, implementation science and most importantly—the impacts of all of these things on people living with HIV.

Having said all that, I love when community and science converge in an intentional way. Particularly when it is driven by members of the HIV community who are versed in science and want to use their access and proximity to research to foster conversations and understanding into the broader community. The Pre-CROI Community Workshop, hosted by TAG (Treatment Action Group), held every year before the Conference on Retroviruses and Opportunistic Infections is one of those spaces. Richard Jefferys pulls this meeting together and it grows year over year. I have attended three of the last four years and this year, co-facilitated the meeting with Micheal Luella (Fred Hutch/defeatHIV Collaboratory), Jeff Taylor (HAR+PS/RidHIV Collaboratory), Luis Shackelford (HVTN) and Danielle Campbell (UCSD/RidHIV Collaboratory).

Held February 21 in Denver, Colorado, the meeting brought research and scientific experts into a space with people living with HIV and translated complex HIV and cure science research and its trials into translatable understanding. This accessibility helps to ensure that advocates and community leaders have the critical information needed to support the HIV community. The thing I think that is far less recognized is that it is also an opportunity for researchers to hear the voices and opinions of the experts outside the lab—those of us living with the virus.

The workshop this year featured seven presentations highlighting infrastructure of cure research and studies about the HIV reservoir (places the virus hides in the body) by Nicholas Chomont of Canada, unique clinical trial designs for HIV cure research focused on analytical treatment interruptions (ATI) and viral rebound once medication is stopped, by Carlo Sacsalan of Thailand. Danielle and I led a conversation and presented data about the

under-representation of women along with their preferences around cure research. Important in the current climate of global HIV, Gaston Devisich of LAC-Cura, the consortium that fosters cure research across Latin America and the Caribbean, impressed upon us the importance of expanding research beyond high-income countries. Rachel Rutishauser helped us examine post-intervention control through a look at biomarkers and immune response, while

Exploring how medications work and why it's necessary to have so many different classes of medication gives me a sense of investment in my treatment.

Shari Margolese talked about collaborative engagement and why it should be treated as core to research. Finally, Linos Vandekerckhove of EU2Cure, which is a European collaborative effort, discussed combination cure approaches and international cure trials.

I'm always amused when basic science comes up as a descriptor about HIV topics because it is *anything* but basic, however, a good presenter such as the ones at the meeting can break the talks down in ways that make it feel approachable and digestible. If I tried to explain a bit of all of these talks this article would be pages long. Fortunately, Micheal and the good folks at defeatHIV have all of the presentations broken up by talk on their YouTube channel. One of the Martin Delaney Collaboratories, the defeatHIV YouTube page also hosts a robust library of other community and science conversations.

Since choosing advocacy as a path within my HIV diagnosis, I have become

increasingly interested in the science behind it. The Human Immunodeficiency Virus is interesting, in fact if one is able to set aside the stigma that comes to the forefront of HIV, it's actually fascinating. As a nurse, it's critical to me that people living with HIV are represented as more than blood, tissue and cell samples.

Personally, I feel better understanding the life cycle of the virus and how it inhabits my body. Exploring how medications work and why it's necessary to have so many different classes of medication gives me a sense of investment in my treatment. I worry about people being able to make informed choices about treatment or understanding the nuance in cure research. Having choice in what you take for HIV management is important, but understanding the origins, mechanisms and history of those choices can bring clarity beyond just feeling like you "have" to take a pill or get an injection because a clinician told you to. I especially think that understanding why cure has been elusive and what combinations of treatment might work to finally make it scalable and equitable for everyone can foster hope and encouragement to those struggling with the diagnosis.

I want to send a huge hug to everyone who was in the room both virtually and online during the meeting. HIV cure is a complex, ever changing field. The support and love of the HIV community for each other doesn't change, and that matters as we navigate this life process. Do yourself a favor, check out the videos. If you learn something, thank a scientist, researcher or an advocate. We're all in this together.

Be well. You matter.

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