POSITIVELY A RE
HIV TREATMENT, PREVENTION, AND SU M TPAN
SEPTEMBER+OCTOBER 2018

AIDS 2018 CONFERENCE UPDATE
REPORT FROM AMSTERDAM

ERIC, ROBERT, TONI-MICHELLE, AND NINA
ARE AMONG THE ADVOCATES WORKING TO CHANGE THE LAWS THAT CRIMINALIZE PEOPLE LIVING WITH HIV

[DE]CRIMINALIZING HIV
BREAK THE CHAINS

HEPATITIS C BEHIND BARS
PRISON HEALTH IS PUBLIC HEALTH

POSITIVELY AWARE

For pagination purposes, this page has been intentionally left blank.

ADVOCATES ASSEMBLE IN ATLANTA

BY **RICK GUASCO**

No sooner had he gotten home to New York from the international AIDS conference in Amsterdam than **Robert Suttle** jetted down to Atlanta to be photographed with fellow HIV criminalization advocates Erik Paulk, Nina Martinez, andToni-Michelle Williams for the cover of POSITIVELY AWARE.

The 39-year-old Shreveport native has been living with HIV for 15 years; for him, HIV criminalization is a personal issue.

"My life was nearly destroyed by a grossly unjust HIV prosecution and conviction," he says. "I served six months in a Louisiana state prison under an HIV non-disclosure charge."

As assistant director of the Sero Project, Suttle coordinates a nationwide network of HIV criminalization survivors, and makes the case for why criminalization affects everyone living with HIV.

"Every person living with HIV is just one misunderstanding or disgruntled ex-partner away from finding him or herself in a courtroom," he says. "A minor infraction of the law or negative encounter with law enforcement while HIV-positive could lead to a felony conviction, a lengthy prison sentence, public shaming and/or registration as a sex offender."

"Georgia is a state in which 54,000 people living with HIV are my neighbors," says **Nina Martinez**, 35, a steering committee member of the Georgia HIV Justice Coalition. Martinez acquired HIV through a blood transfusion when she was six weeks old. "Our state's HIV non-disclosure statute makes it a felony crime for me not to disclose my HIV positive status before engaging in private consensual conduct, without regard to whether or not measures are taken to prevent HIV exposure and transmission; without harming anyone, or intending to harm anyone, I could face up to 10 years of imprisonment.

"This has consequences," Martinez adds. "Women living with HIV like myself are at increased risk of violence, sexual coercion, and can be trapped in unsafe circumstances because of HIV non-disclosure laws that are rife for abuse."

Eric Paulk, 38, is an HIV policy organizer for the LGBT advocacy organization Georgia Equality. "Black communities and other marginalized communities are more vulnerable to being victimized by the criminal justice system than other communities," he says.

Paulk points out that laws criminalizing HIV don't take into account the medical science surrounding HIV, and have been ineffective in containing the virus. "The CDC acknowledges that there is 'effectively no risk' of sexually transmitting HIV when on treatment and undetectable," he points out. "These laws have failed to accomplish their intent of reducing the prevalence of HIV. In fact, there have been no significant public health benefits or reduction in the HIV epidemic—if anything, these laws have exacerbated the epidemic. As such, current practice is bad law and worse policy."

While the focus has been to "modernize" HIV criminalization laws—that is, replacing current statutes or reducing penalties from a felony to a less serious misdemeanor, **Toni-Michelle Williams** wants to see these laws removed altogether. "When we modernize laws we leave loopholes for the folks who are most marginalized and impacted by them," she says.

The Atlanta-born 27-year-old is a leadership development and accountability coach at the Solutions Not Punishment Collaborative (SNaP Co). "Transgender women suffer from profiling, exposing them to sexual harassment and undignified searches that could result in an arrest if they are carrying condoms," she says.

Williams pointed out the need for change. "Criminalization of HIV has made it harder for people [living with HIV] to seek help when they are the victim of a crime, because they risk being arrested. We must challenge the state and utilize its resources to take care of the people directly impacted."

An HIV and civil rights activist himself, photographer **Johnnie Ray Kornegay III** produced the shoot and photographed the cover. Kornegay is founder of Staticc Art & Life, an arts company. Special thanks to the **Center for Civil and Human Rights** museum in downtown Atlanta, which served as the location.

MORE INFORMATION
The Sero Project: seroproject.com
Georgia Equality: georgiaequality.org
Georgia HIV Justice Coalition: thegeorgiacoalition.wordpress.com
Solutions Not Punishment Collaborative: snap4freedom.org
Center for Civil and Human Rights: civilandhumanrights.org
Staticc Art & Life: staticc.com

POSITIVELY AWARE
JOURNALISM. INTEGRITY. HOPE.

A WORLD POSITIVELY AWARE
OF HIV AND RELATED CONDITIONS.

SINCE 1989. PUBLISHED BY
TPAN
5537 N. BROADWAY
CHICAGO, IL 60640-1405
(773) 989-9400
FAX: (773) 989-9494
inbox@tpan.com
positivelyaware.com
@PosAware

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

RIBBON-COVERED BRIDGE IN AMSTERDAM DURING THE AIDS 2018 CONFERENCE.

©MARTEN VAN DIJL-IAS

SEP+OCT 2018

VOLUME 28 NUMBER 6 positivelyaware.com @posaware

EVERY ISSUE

ON THE COVER: **Eric Paulk**, HIV policy organizer at Georgia Equality; **Robert Suttle**, assistant director of The Sero Project; **Toni-Michelle Williams**, leadership development and accountability coach at the Solutions Not Punishment Collaborative; and **Nina Martinez**, steering committee member of the Georgia HIV Justice Coalition **Photographed by Johnnie Ray Kornegay III** at the **Center for Civil and Human Rights** in Atlanta.

THIS ISSUE

JOIN US

positivelyaware

@posaware

inbox@tpan.com

POSITIVELY AWARE
5537 N. BROADWAY ST.
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.

SUBSCRIPTIONS AND BULK ORDERS

Tell us how many copies you want, where to ship them, and who should get them: distribution@tpan.com

'DEPLOY, OR GET OUT' —AN ARMY DOCTOR'S PERSPECTIVE

FIRST OFF, I am an active duty Army Infectious Disease provider and a large portion of my time goes towards care of HIV-positive soldiers. I wanted to start by saying I generally enjoy your POSITIVELY AWARE journal but wanted to clarify something in the July + August issue.

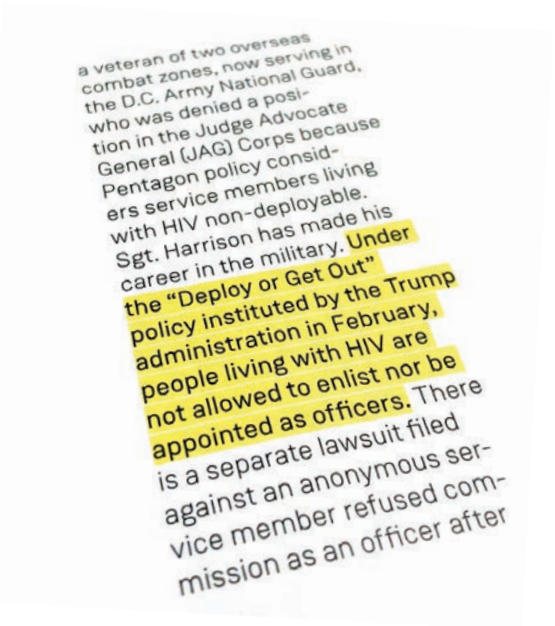
On page 11, it states "Under the 'Deploy or Get Out' policy instituted by the Trump administration, people living with HIV are not allowed to enlist nor be appointed as officers." Technically this has been the policy for years and goes back to Army Regulation (AR) 600-110, which states that people living with HIV are not allowed to join the military, and this was last updated in 2014. I will add a caveat that the new policy *does* say if you are non-deployable, then the goal is to administratively separate you from the military, but most providers taking care of these individuals, myself included, have advised our commands of the error of this policy and it is currently under review.

Also, I should mention that part of the reason for this policy is that all soldiers are supposed to be considered blood donors due to the potential need for a "walking blood bank" during deployment to austere and remote environments and it is because of this that patients with blood-borne diseases are generally considered non-deployable.

Again, I enjoy your journal, but just wanted to make sure that statement was clarified as in this day and age, it seems that it will be easily construed that this was a Trump administration policy, which is technically inaccurate.

Thank you for your time and hope you have a great day! Keep up the great work!

—AARON FARMER
MAJOR, U.S. ARMY PHYSICIAN


a veteran of two overseas combat zones, now serving in the D.C. Army National Guard, who was denied a position in the Judge Advocate General (JAG) Corps because Pentagon policy considers service members living with HIV non-deployable. Sgt. Harrison has made his career in the military. Under the "Deploy or Get Out" policy instituted by the Trump administration in February, people living with HIV are not allowed to enlist nor be appointed as officers. There is a separate lawsuit filed against an anonymous service member refused commission as an officer after

FROM THE JULY+AUGUST ISSUE

EDITOR JEFF BERRY RESPONDS:
Thank you, Dr. Farmer, for the clarifications, and for your dedication. We asked Scott Schoettes, Counsel and HIV Project Director at Lambda Legal, to respond regarding the military's policies:

"That is but one of the justifications for this discriminatory policy—one that is easily knocked down. While it would be ideal if all soldiers could donate blood, there are various reasons a soldier could not do so (including if they are a man who has had sex with another man in the past 12 months). The very small percentage of deployed soldiers who are HIV-positive will not have any noticeable effect on the blood supply at the front lines. We think it is likely the military will offer this as a justification for refusing to deploy people living with HIV, but like other policies that have gone by the wayside (women in the military; 'Don't Ask, Don't Tell,' etc.), it is time for this one to be re-examined and reformed. That which HIV-positive soldiers have to offer is far greater than any minor limitations that may affect their deployment in insignificant ways, such as the inability to donate blood. We look forward to proving in court that people living with HIV are as capable of serving as anyone else."

On July 19 Lambda Legal and OutServe-SLDN, along with pro bono counsel from Winston & Strawn LLP, asked a federal court to halt implementation of a new Department of Defense policy resulting in the discharge of service members living with HIV. Find out more at lambdalegal.org.

EDITOR'S NOTE

JEFF BERRY

HIV Is Not a Crime and me

This past June I had the opportunity to attend my first HIV Is Not A Crime training academy (HINAC 3) in Indianapolis. I have wanted to do a deeper dive and learn more about HIV criminalization for some time, and this was my chance. Plus the conference was in the neighboring state of Indiana so it was just a short drive away. I also saw it as an opportunity to learn what is happening on the ground level with efforts to decriminalize HIV not only in the United States, but also around the world, and to introduce myself to other networks of people living with HIV.

As has been pointed out time and again, and you will read about in this issue, the laws have not caught up with the science when it comes to criminalization of HIV. The indisputable fact that you can't pass on the virus when you are on effective therapy and have an undetectable viral load (U=U) means it's time to update or do away with these laws altogether. Anyone who intentionally tries to infect another person (which is rare and represents only a fraction of the people who end up getting prosecuted under these discriminatory laws) is already covered under non-HIV specific laws.

"U=U has opened up this whole new discourse on reproductive rights," Naina Khana of Positive Women's Network tweeted out during the meeting. "Because we don't just have the right to reproduce, we have the right to have pleasurable sex." Read more about U=U in our AIDS 2018 coverage beginning on page 40.

In this issue Sean Strub, founder of the Sero Project which organizes the biennial conference, talks about how Sero came about, and about the power that comes from networks of people living with HIV when they join together. "Our strength comes from each other, and working with networks like The Reunion Project [for long-term survivors of HIV]," he told the audience. Robert Suttle talks more about the work they are doing on page 16.

I had, and still have, much to learn. Mayo Schreiber, Jr., deputy director at the Center for HIV Law and Policy, pointed out how in the state of Missouri if you kill two people while driving drunk, you're convicted of a felony and sentenced to 5–15 years, and if you *expose* someone to HIV (with no transmission required), you serve the same amount of time: 5–15 years.

Edwin Bernard of HIV Justice Network said during his presentation that the U.S. used to be the world leader in HIV decriminalization, and now "they are the world leader against HIV decriminalization." Read more about the expert consensus statement on HIV criminalization released at the Amsterdam conference on page 46.

Ariel, an articulate young man from Honduras who attends college in Florida, described how he was threatened with HIV criminalization at his university and charged under Title IX for sexual misconduct after a man he was dating filed a complaint—despite there being no risk of transmission.

There was an incredibly moving and powerful criminalization survivors' panel with a call to action. As one person pointed out, the impact lasts past prosecution, conviction and even incarceration—we need a focus on expungement and removal from the sex offender registry as much as a focus on repeal.

"What does it look like to embody a sense of belonging in ourselves?" asked Toni Michelle-Williams, who appears on the cover of this issue. "How do we let go of our shame, so others can walk beside us? Invest in Black Trans Leadership!" she declared.

One of the most moving parts of the conference for me was when Sero board member Kerry Thomas called in during a plenary session to talk about his experience as an advocate behind bars. According to Sero's website Thomas is serving two consecutive 15-year sentences for having consensual sex, with condoms and an undetectable viral load, with a female partner without transmitting HIV, and has become active as an educator and advocate within the walls of the Idaho correctional facility where he is housed.

On the three-hour drive back to Chicago I was still processing the previous four days at the conference in Indianapolis. I began to feel a shift in the way I look at the world and my activism. As I wrote in my Facebook post at the time, "We are in an incredibly difficult and challenging time, but to know that hard-working advocates and policy makers are making significant advances and changes, and developing a strategy and a movement to make change happen, gives me hope. And to begin to try to understand how that, and all my work, absolutely has to happen within a framework of social and racial justice, has me reinvigorated. Thank you to all of those who helped make this happen, my heart and my mind have been opened."

In the empowering words of HIV criminalization survivor Monique, "HIV criminalization did not stop me from anything my heart and mind was willing to do!"

Take care of yourself, and each other.

@PAeditor

The indisputable fact that you can't pass on the virus when you are on effective therapy and have an undetectable viral load (U=U) means it's time to update or do away with these laws altogether.

BRIEFLY

ENID VÁZQUEZ @ENIDVAZQUEZPA

Symtuza approved by the FDA

The first single-tablet regimen containing a protease inhibitor

Another "finally" moment in HIV drug development came in July: the FDA approved the first single-tablet regimen (STR) containing a protease inhibitor.

The HIV protease inhibitor class of drugs created the Lazarus effect in the epidemic, in the late 1990s. Back then, they were difficult to take. Over the years, many protease inhibitors (PIs) dropped off in use. Some are no longer even available.

Darunavir, first approved in 2006 as a new-and-improved PI, has survived. It's not only powerful, but—for the most part—tolerable. It's for these two reasons that darunavir has become the top gun of the protease inhibitors.

The new Symtuza contains darunavir boosted with a small dose of the blood level enhancer cobicistat. It also contains the two medications found in Descovy, emtricitabine and tenofovir alafenamide. The dose is one film-coated tablet once daily with food.

"Many people living with HIV struggle to adhere to their medication, which can lead to the development of drug resistance and potentially cause their medication—or even an entire class of medications—to stop working," said Joseph Eron, M.D., Professor of Medicine and Director, Clinical Core, University of North Carolina Center for AIDS Research, Chapel Hill, N.C., in a press release from Janssen Pharmaceutical Companies.

In fact, the FDA allowed Janssen to advertise Symtuza as "help[s] protect against resistance."

"In key Phase 3 clinical trials, Symtuza successfully treated those who were starting therapy," said Dr. Eron, "as well as those who were stably suppressed on antiretroviral (ARV) therapy—including patients with more complex treatment histories or previous virologic failure—demonstrating its potential as an important new treatment option for a wide variety of patients."

At this moment in time, U.S. HIV treatment guidelines recommend the newer integrase inhibitor (INSTI) drugs for first-time therapy in "most people with HIV."

Only two PIs are recommended for initial therapy, and then "in certain clinical situations." Of the two, darunavir is preferred over atazanavir.

The treatment guidelines from Health and Human Services list reasons why the INSTIs are preferred for most individuals. Then it states that, "An exception is in those individuals with uncertain adherence or in whom treatment needs to begin before resistance testing results are available (e.g., during acute HIV infection, pregnancy, and in the setting of certain opportunistic infections). In this context, DRV/r [darunavir boosted by ritonavir] may have an important role given the low rate of transmitted PI resistance, its high genetic barrier to resistance, and low rate of treatment-emergent resistance during many years of clinical experience."

HHS uses bioequivalence data comparing cobicistat-boosted darunavir to ritonavir-based darunavir to recommend cobicistat-boosted darunavir for initial use. DRV/r does not have this recommendation.

Of note, the guidelines immediately pointed out that dolutegravir, an INSTI, may also be considered for use before resistance testing results are available. Symtuza may also be used in this scenario, as long as people taking it have had undetectable viral load for at least six months before going on it. Moreover, unlike the other HIV drugs, people with previous treatment failure were allowed to enter into Symtuza clinical studies. Approximately 15% of participants had previous HIV treatment failure.

The guidelines also point out that "an observational cohort study suggested that DRV/ritonavir is associated with increased rates of cardiovascular disease; data on DRV/cobicistat are too limited to draw conclusions."

Darunavir contains a sulfa component, so it should be used with caution by people with sulfa allergies. Diarrhea, rash, and nausea were reported in clinical research. Severe rash with darunavir is rare but potentially life-threatening.

Check for hepatitis B before taking Symtuza.

Another side effect is the price: around $40,000 a year, the highest ever for an HIV pill. There is a free 30-day start program for new Symtuza users and the co-pay assistance program has gone up to $10,500.

Darunavir is available under the brand name Prezista, and is also found in the co-formulated pill Prezcobix (with cobicistat). Compared with tenofovir DF, found in Truvada, the tenofovir alafenamide (TAF) in Symtuza is safer on kidney and bone health. Also as a result of the TAF, Symtuza can be taken by people with more advanced kidney disease, down to a renal function (CrCL) of 30. Go to positivelyaware.com/symtuza.

Intelence now for children ages 2–5 years

The HIV medication Intelence (etravirine) has been approved by the FDA for use by children ages 2 to 5 who weigh at least 22 pounds (10 kg). The dose is 100 mg twice daily (the adult dose is 200 mg twice daily). The FDA reiterated instructions for those unable to swallow the tablets whole with water. Follow instructions on the label. Intelence is a non-nucleoside reverse transcript inhibitor (NNRTI). The approval came in July. See positivelyaware.com/intelence.

Monthly injection for HIV

ViiV Healthcare reported finding similar efficacy for a once-a-month injection of two HIV medications at one year compared with a regular oral triple-drug antiviral regimen. The injectable combination used ViiV's cabotegravir, which is still in development, along with Janssen Therapeutics' rilpivirine. The global ATLAS Phase 3 study included 618 men and women from around the world.

Generic Suboxone approved by FDA

The FDA in June approved two generic versions of the opioid dependence medication Suboxone.

"The FDA is taking new steps to advance the development of improved treatments for opioid use disorder, and to make sure these medicines are accessible to the patients who need them. That includes promoting the development of better drugs, and also facilitating market entry of generic versions of approved drugs to help ensure broader access," said FDA Commissioner Scott Gottlieb, M.D., in a press release. "The FDA is also taking new steps to address the unfortunate stigma that's sometimes associated with the use of opioid replacement therapy as a means to successfully treat addiction. Patients addicted to opioids who are eventually treated for that addiction, and successfully transition onto medicines like buprenorphine, aren't swapping one addiction for another, as is sometimes unfortunately said. They're able to regain control of their lives and end all of the destructive outcomes that come with being addicted to opioids. When coupled with other social, medical, and psychological services, medication-assisted treatments are often the most effective approach for opioid dependence."

PrEP development guidance

The FDA in June issued a draft guidance on the development of products for PrEP (pre-exposure prophylaxis). "Specifically," the agency announced, "this guidance addresses the FDA's current thinking regarding the overall development program and clinical trial designs to support the development of systemic drug products for the prevention of HIV-1 infection." The guidance focuses on long-acting products. Go to http://bit.ly/2ODfasF.

CDC updates TB guidelines

The Centers for Disease Control and Prevention (CDC) released updated recommendations for use of once-weekly isoniazid-rifapentine for 12 weeks (called "3HP") for treatment of latent tuberculosis infection. The updated recommendations support expanded use of an effective, shorter treatment to reach even more people with latent TB infection. This includes people living with HIV/AIDS who are taking antiretroviral medications with acceptable drug interactions with rifapentine.

"Because HIV infection weakens the immune system, people with latent TB infection and HIV infection are at very high risk of developing TB disease, if not treated," the CDC reported in a press release. "Previously, CDC only recommended the 3HP regimen for treatment of latent TB infection in people with HIV who were otherwise healthy and not taking antiretroviral medication. At that time, we did not know enough about the interactions between rifapentine and certain antiviral medications. New data now show an absence of clinically significant drug interactions between once-weekly rifapentine and the antiviral medications efavirenz [brand name Sustiva, found in Atripla] and raltegravir [brand name Isentress]."

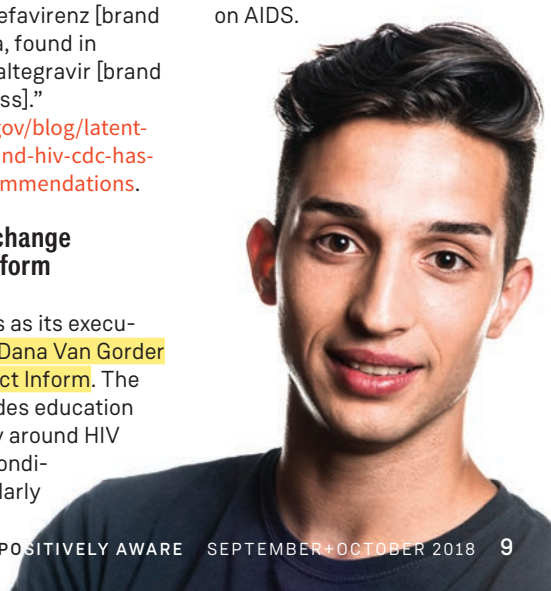
Go to hiv.gov/blog/latent-tb-infection-and-hiv-cdc-has-updated-recommendations.

Leadership change at Project Inform

After 10 years as its executive director, Dana Van Gorder has left Project Inform. The agency provides education and advocacy around HIV and related conditions, particularly working towards an HIV-free generation. Project Inform services include two hotlines (800-822-7422 and HELP-4-HEP) and the writing of the annual Hepatitis Drug Guide, published in POSITIVELY AWARE. Long-time Director of Research Advocacy David Evans, a prominent writer and activist, was appointed in June by the Board of Directors as Interim Executive Director.

Latino Gay/Bi Men's Health Summit

The first Latino Gay/Bi Men's Health Summit took place in late June in Albany. The New York State-based effort sought to enhance and contribute to the state's efforts on ending the AIDS epidemic and develop a health agenda on other health issues affecting Latino gay and bi men in the state. The summit gathered nearly 50 Latino gay and bi men representing 35 organizations as well as the health departments of New York City and New York State. It was organized by the NYS Latino Health Network, Hispanic Health Network, and the Latino Commission on AIDS.



ISTOCKPHOTO

BRIEFLY

New campaign aims to 'Cut the Stigma'

Lambda Legal, the national rights organization for the LGBTQ community, and Los Angeles-based Black AIDS Institute (BAI) have teamed up for an education campaign called *Cut the Stigma*, focusing on black communities to "dispel misconceptions surrounding the transmission of HIV and reduce HIV stigma and its resulting discrimination." The campaign was developed after the owner of an L.A. barbershop refused to cut the hair of a customer living with HIV.

"My experience at the Leimert Park barbershop was not the first I have had with HIV discrimination. Today, I am speaking out because I would like it to be my last," said Nikko Briteramos, 34, who has been living with HIV since he was 19, in a press release. "I want everyone to hear my story so they can better understand how harmful these moments of discrimination can be to those living daily with HIV. The stigma is a result of misconceptions and it needs to end."

Scott Schoettes, Counsel and HIV Project Director at Lambda Legal, said, "The facts of this case, as well as the legal claims, are pretty straightforward: the owner of King of Kuts in Leimert Park refused to cut Nikko's hair because he is living with HIV, in clear violation of the federal Americans with Disabilities Act (ADA) as well as the California Unruh Civil Rights Act. While we work within the legal system to remedy the dignitary harms Nikko suffered as a result of this discriminatory encounter, we are also partnering with Black AIDS Institute to engage with Black communities nationally to do some critically important public education to prevent such discrimination from happening in the first place."

"It was important for BAI to get involved in Nikko's case because there's no way to end the AIDS epidemic if we're not fighting bigotry, discrimination, and bias," said Phill Wilson, CEO and founder of the Black AIDS Institute. "In addition, as a Black organization, we have to be ever vigilant in confronting injustice. It is a part of our survival. We fight those injustices to survive—and this is a case about injustice. It's about bias. It's about bigotry. It's about discrimination. We have an obligation to be at the forefront of that effort; that's essential."

Wilson continued, "We are well aware that HIV discrimination does not only occur in the Black community. But Nikko's experience highlights how Black people living with HIV are often confronted with discrimination connected to stigma and misinformation in public places of importance within our community. The barbershop is a sacred social space, where Black Americans debate social, cultural, and political ideas. HIV discrimination destroys such safe spaces. Through this partnership with Lambda Legal on *Cut the Stigma*, Black AIDS Institute intends to engage barbers across the country in an effort to end the harmful effects of HIV discrimination that stems from misinformation."

TO LEARN MORE about the case, go to lambdalegal.org/nikko. For more about the *Cut the Stigma* campaign go to blackaids.org/CutTheStigma.

Mavyret and HIV data

The FDA in August added HIV data to the drug label for the hepatitis C medication Mavyret (glecaprevir and pibrentasvir).

In the EXPEDITION-2 study, there was a 98% cure rate (a sustained virologic response, or SVR)— 150 out of the 153 participants living with HIV who were taking Mavyret. The ones who did not have cirrhosis took Mavyret for 8 weeks, while the ones with compensated cirrhosis (11%) took it for 12 weeks.

Side effect information was also added. In the ENDURANCE-1 and EXPEDITION-2 HIV/hepatitis C co-infection studies, participants had a similar safety profile as that seen among those who only had hep C. Adverse reactions observed in at least 5% of people taking Mavyret in the EXPEDITION-2 study (whether for 8 or 12 weeks) were fatigue (10%), nausea (8%), and headache (5%). Data were also added regarding people who have had liver or kidney transplants.

For more information, go to drugs@fda.gov.

ISTOCKPHOTO

Condoms and mistrust

London-based researchers surveying people in several African countries found that "condoms were often seen as symbolic of infidelity and mistrust, and therefore only appropriate in short-term relationships," according to

AIDSmap. They also looked at the attitudes around PrEP use.

"Emerging interventions, whose symbolic meanings are being constructed anew, may be uniquely positioned to infuse their 'brand' with associations compatible with love, commitment, responsibility, and sexual pleasure, rather than those associated with disease, danger, and distrust," Emily Warren and colleagues at the London School of Hygiene and Tropical Medicine wrote. "If interventions have positive symbolic meaning and are understood to have fewer risks associated with them, uptake and adherence may improve."

Read Roger Pebody's report at aidsmap.com/page/3304079. Go to page 35 to read about HIV infection among gay and bisexual male couples.

Genvoya, Stribild and Tybost with anticoagulants

New drug interactions were added to the labels for Genvoya, Stribild and Tybost. The FDA in August added information on taking these HIV meds with a direct oral anticoagulant (DOAC). See chart below.

Apixaban (brand name Eliquis) with Genvoya, Stribild, Tybost/Prezista or Tybost/Reyataz:
Due to potentially increased bleeding risk, refer to apixaban dosing instructions for coadministration with strong CYP3A and P-gp inhibitors in apixaban prescribing information.

Rivaroxaban (brand name Xarelto) with Genvoya, Stribild, Tybost/Prezista or Tybost/Reyataz:
Coadministration of rivaroxaban with Genvoya, Stribild or Tybost is not recommended because it may lead to an increased bleeding risk.

Betrixaban (brand name Bevyxxa); dabigatran (brand name Pradaxa); and edoxaban (brand name Savaysa) with Genvoya, Stribild, or Tybost/Reyataz:
Due to potentially increased bleeding risk, dosing recommendation for coadministration of betrixaban, dabigatran or edoxaban with a P-gp inhibitor such as Genvoya, Stribild or Tybost plus Reyataz depends on the direct oral anticoagulant indication and renal function. Refer to the DOAC dosing instructions for coadministration with P-gp inhibitors in the DOAC prescribing information.

Betrixaban, dabigatran or edoxaban with Tybost/Prezista:
No dose adjustment.

FOR MORE INFORMATION, GO TO drugs@fda.com.

ENDING CRIMINALIZATION OF HIV

Having experienced his own ordeal, activist **Robert Suttle** adamantly believes we are destined to win

PHOTO: JOHNNIE RAY KORNEGAY III

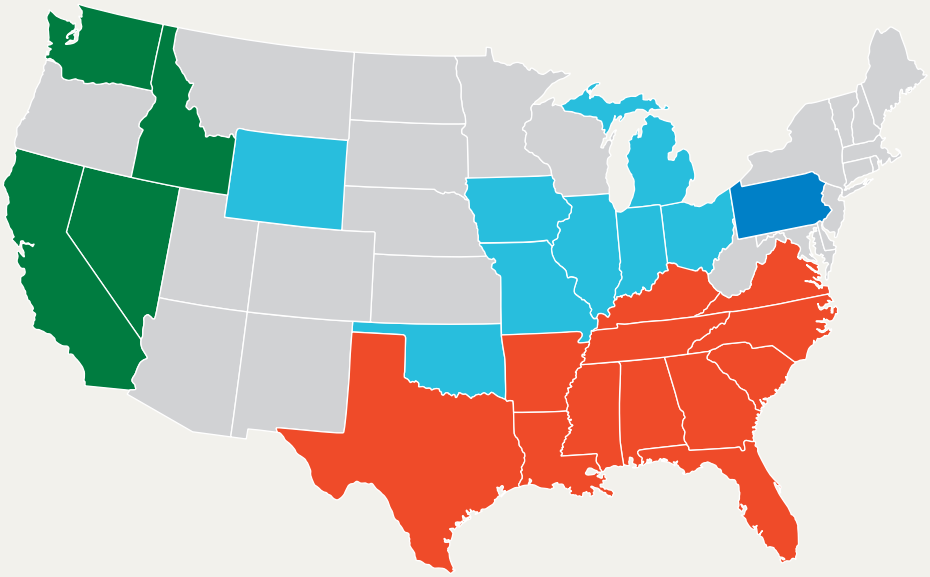
GETTING INVOLVED in the movement to end HIV criminalization became the saving grace for my survival. As a person living with HIV, the experience of being persecuted by HIV criminalization changes you. Collateral and social consequences of a grossly unjust prosecution and conviction don't simply end upon one's release from prison. Social stigma and mental health challenges affects one's day-to-day life making it, at times, all the more difficult to cope.

Although HIV criminalization remains a major issue, I am optimistic about the future, that our movement will continue to grow and build power to create change, challenging the status quo in every state across the country. It's already starting to happen.

From hundreds of public events, ranging from professional conferences to community forums, it has been remarkable to witness the growing interest in ending HIV criminalization and the coalescing of national networks of activists and advocates, particularly people living with HIV, along with social justice groups; community organizers; public health, criminal justice, medical and scientific professionals, and political and public policy leaders. We've got allies today who only a few years ago we might have thought unlikely.

Much has changed since 2012, when the Sero Project, a network of people living with HIV and allies fighting against stigma and injustice, was launched, leading me to believe that **we are destined to win!** For example, several states—Iowa, Colorado, California, and North

WHERE DECRIMINALIZATION EFFORTS ARE TAKING PLACE



Many statewide coalitions or working groups have formed, since the inaugural 2014 HIV Is Not a Crime in Grinnell, Iowa, starting state-level strategic planning and reform efforts or demonstrating some level of interest in some of the following states:

SOUTHERN REGION
Alabama, Arkansas HIV Reform Initiative, Florida HIV Justice Coalition, Georgia HIV Justice Coalition, Kentucky, Louisiana Coalition on Criminalization and Health (LCCH), Mississippi, North Carolina, South Carolina, Tennessee, Texans Living with HIV Network (TLHIV), Virginia

MIDWEST REGION
Colorado Mod Squad, Illinois, HIV Modernization Movement - Indiana, Community HIV/Hepatitis Advocates of Iowa Network (CHAIN), Michigan Coalition for HIV Health and Safety, Missouri HIV Justice Coalition (MHJC), Ohio Health Modernization Movement, Oklahoma

NORTHEAST REGION
HIV Is Not a Crime Pennsylvania Working Group

WESTERN REGION
California for HIV Criminalization Reform (CHCR), Idaho Coalition for HIV Health & Safety (ICHHS), Nevada, Washington

Carolina—have made significant victories by amending statutes and health codes related to HIV "criminal exposure" and "HIV control measures." That's solid progress.

HIV Is Not a Crime training academies—held in 2014 in Grinnell, Iowa; in 2016 in Huntsville, Alabama; and earlier this year in Indianapolis—urge us to use an intersectional lens to connect with other social justice struggles, and remind us of the importance of centering the voices and leadership of people living with HIV and other communities disproportionately impacted by criminalization in all its forms.

Recognizing that criminalization in the U.S. disproportionately impacts Black people, the first-ever Black United Leadership Institute (BULI), convened at HIV Is Not a Crime III in Indianapolis this past summer, to elevate and support a robust network of Black leadership, especially people living with HIV, who are involved in state-level HIV criminalization reform efforts. Any effort to abolish HIV criminalization that is authentic must center racial justice and leadership by people living with HIV and people of color.

As people living with HIV (PLHIV) and survivors of criminalization, our voices and participation in the movement continue to have a profound impact. Our willingness to shed our shame, speak up and share our stories—to do this has done more to raise awareness and mobilize grassroots action to change statutes than anything else. Absent our voices—and the many other PLHIV who have spoken up since—this movement would look very different today, certainly less robust and vibrant and more likely been created *around* PLHIV than *by and with* PLHIV. The difference would be profound.

One of the Sero Project's strategies is to build and strengthen networks of people living with HIV in a number of states. Networks are persuasive and powerful advocacy tools, and have led to the growth of organizing around HIV criminalization in many states.

We are destined to win! That's why today, I implore every person living with HIV, every advocate, every activist and ally, to join in the movement to getting to zero prosecutions. #HIVisNotaCrime! Get educated and active within your state coalition and learn why HIV criminalization laws are ineffective, unwarranted, and discriminatory. You care about HIV criminalization, you just don't know it yet. We need your support and involvement to make sure we take the path that will improve public health and deliver on the promise of justice to every person, including those of us who have HIV.

FOR INFORMATION on HIV criminalization in any specific state, or on advancing advocacy for criminalization reform in your state, go to seroproject.com or email info@seroproject.com.

ROBERT SUTTLE is the Assistant Director of the Sero Project. He oversees community outreach and education, and coordinates the Sero Project's HIV Criminalization Survivors Network.

HE SAID, SHE SAID —AND WHAT THE LAW SAYS

A doctor who works with people with HIV who are incarcerated looks at two cases

BY **CHAD ZAWITZ, MD**

Enacted in 1989, Illinois' HIV Criminal Transmission Law has undergone minor revisions since then, but remains no less controversial. In the era of U=U (Undetectable=Untransmittable), PrEP, treatment as prevention (TasP, e.g., HPTN 052 and other studies), as well as enlightenment about HIV in general, it is time to reconsider the consequences of this law.

I have worked at the Cook County Jail in Chicago for 14 years. In that time, I have provided HIV medical services to a number of patients who were in custody awaiting trial over alleged violation of the HIV Criminal Transmission Law. The purpose of this article is not to suggest innocence or guilt of the alleged, but to provide real-world examples of how this law has affected patients from the perspective of the incarcerated and those who care for them. Names and specific details of criminal allegations have been modified to protect privacy.

Mr. Xavier has been in jail since 2014, charged with HIV Criminal Transmission. During a slow day in clinic, he decided to share his version of the allegations with me. He had been in a long-term relationship with his girlfriend. They have one child together, and he has two other children from a previous partner. The two of them apparently got into a heated argument ultimately leading to the end of their relationship. However, that was not the end of the fight's consequences.

Xavier alleged that out of spite, his now ex-girlfriend called the police and stated that he intentionally tried to infect her with HIV by not disclosing his status. She alleged that she discovered his medications, researched what they were, realized she was unaware, and had been having unprotected sex for years. Despite not contracting HIV, she was able to have Xavier incarcerated.

Xavier told me his girlfriend had always been aware of his status. He said she even came with him from time to time to his medical appointments with his HIV specialist, as it was part of their family planning to minimize her risk while trying to conceive. He was adherent to his medication and had an undetectable viral load. Despite this, he has spent nearly four years behind bars awaiting trial.

During his lengthy incarceration, Xavier has lamented not being there for his children, particularly his then three-, now seven-year-old,

ISTOCKPHOTO

son he had with his now ex-girlfriend. He told me the prospect of a felony conviction would "destroy" his future. He has lost his job, his apartment, his car, and some of his friends. His reputation in the community has been damaged. His HIV status is no longer private information among his family and friends. At times, he told me, he was so depressed he had considered suicide.

In a different state correctional institution, another example of HIV criminal transmission occurred. In this case, Angelica, a 21-year-old transgender female who is HIV-positive, was incarcerated for theft. She refused to take antiretroviral medications during her sentence for personal reasons, and had a very high plasma viral load. She was "ticketed" by the Department of Corrections for having sexual relations with multiple partners during her incarceration.

One of her sex partners had been in the system since 2013. Max had been tested for HIV at least annually during his incarceration, negative each time. In 2017 he tested positive. During an inquiry, he acknowledged his most recent sex partner was Angelica. Max stated he was not aware of her HIV status, and denied being with any other partners since his last negative test. All the sex was consensual, but due to condoms being contraband at this institution, it was unprotected. PrEP was not offered or available.

The medical provider felt he had an ethical dilemma. He knew both patients. He knew the infection most likely resulted from Angelica declining to take medications. Max claimed he did not have any discussion with any of his partners about HIV or other sexually transmitted infections. Angelica stated she did not disclose her HIV status prior to or after sexual activity with any of her partners. Max and Angelica were not married or civil partners (in Illinois, the AIDS Confidentiality Act gives a medical provider the right to disclose without consent in the instances of marriage and civil partnerships, but not other relationships).

Knowing the criminal transmission laws in his state, this doctor was torn between strictly observing medical confidentiality, or informing Max of the law in the context of his new infection. Moreover, was it even his role to get involved in such a legal issue when his job was to provide medical care? Was he obligated to notify the Department of Corrections in some manner to consider housing Angelica separately from other inmates to minimize the risk of additional new sexual exposures? Should he have considered the possibility of inmate retaliation against Angelica?

These cases illustrate some additional perspectives of the impact of criminalizing being HIV-positive. However, they also bring up numerous related points for discussion:

- If any intimate partner can report someone else's HIV status to the police, **do all HIV positive people need to consider if they need some sort of "evidence" to support their disclosure?** This would include everyone who has ever used hook-up apps or the internet to find sex partners.
- **What role/responsibility does a Department of Corrections have** in providing access to HIV prevention during incarceration?
- **Why is HIV singled out as the only sexually communicable disease that is criminalized** for lack of disclosure? Many if not most sexually communicable diseases can cause lifelong complications and even death (e.g., hepatitis B and C, human papillomavirus, herpes simplex, syphilis, chlamydia, gonorrhea, MRSA).
- **Who is ultimately responsible for protecting one's health?** You? Your partner? The legal system? The healthcare system?
- **Is disclosing someone's HIV status without consent (e.g., calling the police) a violation** of the Illinois AIDS Confidentiality Act (or the laws of other states)?
- In the era of PrEP, PEP, U=U, and treatment as prevention, **does the science of HIV transmission still align with real-world risk** warranting incarceration?
- **How does one prove intent** to infect a sexual partner? Would wearing a condom be proof of lack of intent? Would taking one's medications and having an undetectable viral load? Would an HIV-negative partner taking PrEP be at inordinate risk?
- **Should the Criminal Transmission law be revised again to reflect our current science** regarding the real risk of HIV transmission? Should the law be eliminated altogether?

I do not have answers to clear the air, but I do understand the science behind disease transmission. The way the law currently exists, it may simply boil down to "He said, she said." May the most compelling story to the judge and jury "win"? PA

CHAD ZAWITZ, MD, is a Board Certified Infectious Diseases specialist at Cook County Jail in Chicago. He received his Infectious Diseases training at Rush University Medical Center in Chicago and Internal Medicine training at the University of Pittsburgh. He is the Director of the Continuity of Care Clinic for HIV-positive detainees at both the jail and the nearby county-run CORE Center. He is also a Certified Correctional Healthcare Provider (CCHP). Dr. Zawitz has worked exclusively with the incarcerated population in Chicago for more than 10 years. His academic interests include virology (HIV/HCV), correctional healthcare, public health, and LGTBQ health.

A matter of culture and rights

Two activists discuss decriminalization efforts in Mexico and the U.S.

BY **LEONARDO BASTIDA** AND **MARCO CASTRO-BOJORQUEZ**

JOURNALIST AND HISTORIAN Leonardo Bastida, based in Mexico City, and Marco Castro-Bojorquez, an activist and filmmaker of Mexican descent living in California, met at the HIV is Not A Crime (HINAC) activist training academy, organized by the SERO Project and Positive Women's Network-USA. Here, they discuss HIV criminalization, specifically against queer and other marginalized communities, here and in Mexico.

BASTIDA

CASTRO-BOJORQUEZ

HIV criminalization in the U.S.

LEONARDO BASTIDA During the last HIV Is Not A Crime (HINAC 3) training academy [in June], one of the issues brought to light was that African Americans were more likely to be prosecuted for criminal transmission of HIV than other racial groups. How do ethnicity and race affect other groups such as Latinos, whose members grow up in another cultural context, many of whom have been denied, or do not have, legal immigration status?

MARCO CASTRO-BOJORQUEZ HIV is a racial issue, an economic issue, and a cultural issue. For the longest time the behavior or personality traits of people of color were blamed for the higher rates of HIV and other STIs, when in reality the socioeconomic aspects of people's lives, racial discrimination, stigma, and geography, to name a few, are factors that determine how HIV affects a person in their lifetime. At HINAC 3 there was a Black United Leadership Institute (BULI) right before the conference and this event gave our colleagues of African descent an opportunity to engage around a series of issues affecting black Americans, but more importantly, they had the opportunity to be among other black advocates.

People of color are disproportionately affected by HIV in the U.S., especially women, young people, and LGBTQ folks. We lack access to testing, prevention, care, and accurate data due to lack of inclusion in research. That's why recently a group of national HIV/AIDS advocates of color, myself included, created HIV Racial Justice Now, a collaborative group of leaders in the community, and we drafted a framework called *A Declaration of Liberation: Building a Racially Just and Strategic HIV Movement*. With this framework, we hope to inspire other leaders of color working in HIV to demand racial justice within our movement, and we are working with organizations and research groups that are interested in adopting it as they engage in HIV care, prevention, research and advocacy so that they analyze and adjust their practices and create meaningful change in their communities.

BASTIDA In most of the states that belong to the American Republic, the law punishes people living with HIV who do not reveal their status. Do these actions help to diminish new HIV infections or just control a person's sexuality as a kind of biopolitics in order to relate sex to a reproductive matter?

CASTRO-BOJORQUEZ These actions do not help anything or anyone!

Any law criminalizing someone's health condition is a bad law.

We don't need for the government to send us to jail because we're sick. We need health care, housing, food, and jobs, and we need for the government to stop trying to kill us, that's what we need. People living with HIV in the U.S. aren't going to be quiet or passive. We've been fighting for our lives since the beginning of the pandemic and we'll continue to do so. I would fight till the day I die so we can be treated equally and with respect.

HIV criminalization is not just an HIV issue but affects all communities, especially those that are the most marginalized, like women, transwomen, sex workers, people that use drugs, and people of color in general. There's a disruption in anyone's life once you're criminalized because of your HIV status. Every aspect of your life gets negatively affected and it is something I don't wish anyone to experience, and so my heart goes out to our HIV criminalization survivors and their families!

BASTIDA How difficult is it to modernize laws in a country that does not care about human rights, in fact, prefers to call them "civil rights," and does not accept international recommendations from global agencies and organizations, such as the United Nations or the Organization of American States?

CASTRO-BOJORQUEZ It isn't easy but it is possible. I was a lead organizer in California in the efforts to modernize HIV laws and it was a monumental effort. We fought for over three years and there were really difficult times, both internally in our work as a coalition and externally in some of the reactions from the public's lack of awareness, but we did it. It wasn't perfect but I know that, for now, I don't have to worry about being sent to prison because of my HIV status.

In my opinion, we need to abolish all these laws and not just "modernize" them, but I understand it is a process. All people unjustly incarcerated right now should be freed and returned to their homes with their loved ones. Because HIV is Not a Crime!

When I participated in the so-called "National HIV/AIDS Strategy" and the word

PHOTOS COURTESY OF BASTIDA AND CASTRO-BOJORQUEZ

SPIRITS RAISED: Castro-Bojorquez in front of an altar he created at HINAC 3, with friend and fellow activist Carrie Foote.

PHOTO COURTESY OF CARRIE E. FOOTE

"immigrant" was nowhere to be found, I realized that my work needed to be more intentional and embrace human rights principles as my personal framework in any efforts in which I am involved. Just recently I was invited into an important fellowship, by the U.S. Human Rights Network, to their 2018 Fighting Injustice through Human Rights Education (FIHRE) program. As a USHRN FIHRE fellow, I would more formally incorporate human rights principles into my work in HIV/AIDS.

BASTIDA Some of the activities at the HIV Is Not a Crime academy were related to art. What is the relevance of using artistic projects to sensitize populations about a problem such as HIV criminalization?

CASTRO-BOJORQUEZ Diego Rivera said that every Mexican child is born an artist. I love being an artist and an activist, and I honestly feel that it is with my filmmaking that I better express myself and feel the most connected to people. At HINAC 3 we had different expressions of art, from a poster contest, films, ballroom à la "Indianapolis is burning"—and my altar! [In Mexican culture, an altar pays tribute to the dead.]

For the second time around, I was fortunate to create an altar at the conference to honor the legacy of our sisters and brothers who died because of complications with AIDS and to embrace the idea of celebration even in death. I loved the connections I made during the evenings the altar was open and the stories we heard as a collective.

HIV criminalization in Mexico

CASTRO-BOJORQUEZ When I was in Mexico City in 2017 and doing transformative HIV work with you, among other brilliant people, I noticed a tremendous division among the LGBTQ community. I even heard a dear friend saying that "straight people living with HIV have less rights than LGBTQ people living with HIV." Can you speak to how these divisions in our own queer community affect people living with HIV/AIDS in Mexico?

BASTIDA I think that Mexican society, as a diverse entity, is comprised of many opinions and thoughts. In fact, all people should have their own ideas and beliefs. However, it is necessary to agree on general points of view when we talk about common agendas and goals. In this case, to improve the lives of people living with HIV, their conditions and rights. At this time, we have not established a common agenda on HIV. There are so many movements, focused on different goals. For example, a special group for women, another for sex workers, another one for young people and many for LGBTQ persons. But these movements don't work together and just partially share some goals.

Universal access to antiretrovirals is partial; discrimination is still part of their lives; more than 20 percent of new HIV infections are not detected; co-infections are not treated at all; and there are special criminal laws for people living with HIV.

CASTRO-BOJORQUEZ At HINAC 3 you were part of the Mexican delegation and represented the newly formed *Red mexicana de organizaciones contra la criminalización del VIH* (Mexican Network of Organizations Against the Criminalization of HIV). Why was it important for people here in the U.S. to learn about the HIV work done in Mexico and Latin America?

BASTIDA Language represents a big barrier between Mexico and Latin America and the United States and Canada. Many times, it seems that the North and the South are totally different so, apparently, we cannot build common bonds in spite of the fact that we share many problems. One of them is HIV criminalization in our laws. The HIV Justice Network has documented that the U.S. is one of the countries where most persons have been prosecuted in the whole world. Mexico

does not appear on that list, but 30 of the states that belong to the Mexican Republic have legal frameworks similar to the American ones.

We could see during the training sessions that many delegates didn't know that, or of the existence of a Mexican movement. In addition, they didn't know that in Mexico the Supreme Court has ruled that laws which punish people living with HIV are not constitutional because they are discriminatory.

In the sessions, we explained how persons who belong to different NGOs [non-governmental organizations] and are from different cities and countries, such as you, could gather together and implement a strategy, at several levels, that could reach public and political spaces where decisions and changes can be made.

We shared our experience in the Veracruz case, a Mexican state that in 2015 changed its law to criminalize HIV. As a result of that, Grupo Multisectorial en VIH-SIDA del Estado de Veracruz [the Multisectorial Group in HIV-AIDS in the State of Veracruz] asked the National Human Rights Commission to declare the law an unconstitutional action because it affects the rights of people living with HIV. That action was submitted to the National Supreme Court and discussed in 2018, three years later. The result was a declaration that the law was invalid.

We think that this experience can help our brothers and sisters create their own interdisciplinary strategy and reach a law modernization in their state, and why not in the whole country?

CASTRO-BOJORQUEZ "Molecular Surveillance" was an important topic I first heard about at HINAC 3. What were some of the lessons you learned at the conference?

BASTIDA One of the most important lessons I learned was that we need to keep on together, no matter the languages, nationalities, health condition, race, sexual orientation, gender identity or expression, to improve life conditions and guarantee human and civil rights of people living with HIV.

Molecular surveillance means that there is a collection of HIV data to support health systems in monitoring trends on new HIV infections, the use of antiretroviral therapies, and co-infections. Socially, molecular surveillance could mean that we can join together our experiences in modernizing laws and other issues that benefit directly people living with HIV into a database in order to apply them if it is needed or as a guide in making new prevention strategies.

CASTRO-BOJORQUEZ I am so grateful for the human rights work for and with people living with HIV in Mexico by people like you and our dear friend and colleague Patricia Ponce from Grupo Multi, and many others. Can you share the biggest issues affecting people living with HIV in Mexico? And also, how is it that HIV criminalization has been a topic that has resonated with the Mexican people?

BASTIDA For many years, Patricia Ponce has been interested in HIV social research and in public incidence to help improve the political situation in Veracruz. Part of her work is making visible the needs of people living with HIV and the injustices against them. That is the reason Grupo Multisectorial questioned Mexican HIV criminalization laws.

During the last two years, our states proposed legislation that punish a possible HIV transmission. In Veracruz, it was presented as a solution to diminish rates of HIV in women. Fortunately, it was cancelled by the Supreme Court.

Another case occurred in Chihuahua, where a representative proposed a similar amendment. It was removed some days later.

In San Luis Potosí, the governor tried to punish HIV transmission, but the House of Representatives rejected it after some months.

In Quintana Roo, laws were amended in a negative manner.

After some protest from NGOs, some representatives agreed to modify legal texts, but their deadline is almost here and they have not done it yet.

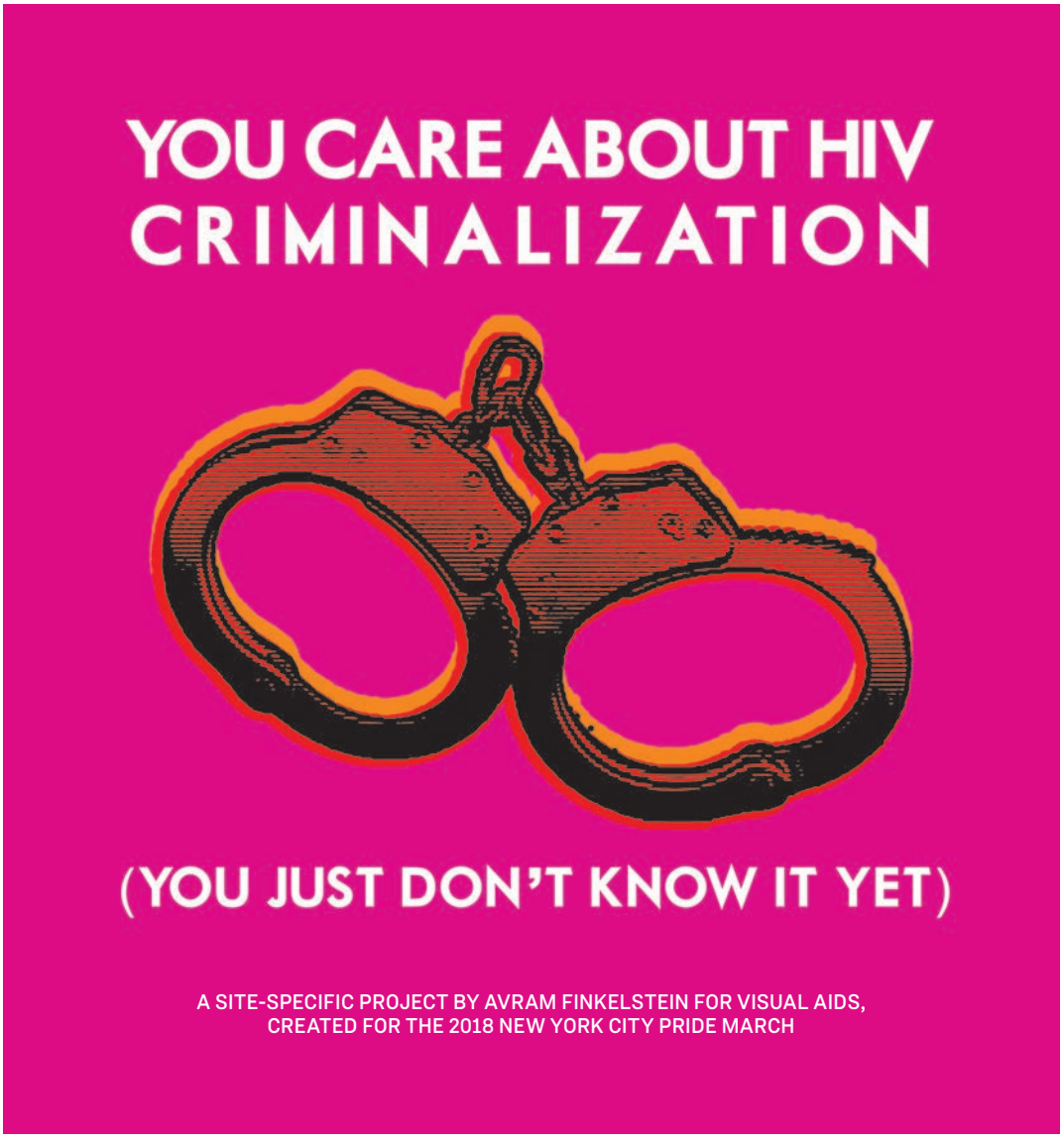
These propositions are a result of huge ignorance about HIV and AIDS. Many people, including legislators and government officials, still think that HIV is synonymous with death and they have other prejudices as well. Therefore, discrimination against people living with HIV is a big challenge to defeat. Some figures, shown by the National Council to Prevent Discrimination, show that almost 40 percent of Mexican society would not agree to live with a person living with HIV.

That is the reason why I believe the biggest challenge in Mexico is to eradicate prejudices and discrimination, with sexual education in elementary schools, more informative campaigns, positive messages in media, training in medical and public services, focused strategies to prevent new infections, and normalized HIV testing. PA

STATEMENTS FROM THE WRITERS

Leonardo Bastida: For several years I have focused on the oral history of Mexican immigrants in the United States and the social networking of MexAmerican communities in borderlands. In addition, I have worked as a journalist at La Jornada newspaper following human rights, LGBTQ and gender issues, migration, and HIV. During the last two years I have been involved in a social movement against HIV criminalization in Mexico, after as an investigative journalist I learned that 44 people have been prosecuted because of possible HIV transmission. In not one case could it be demonstrated that the person was guilty. However, judges considered their attitudes and actions a felony. As a person interested in human and civil rights, I believe that no one should be prosecuted or discriminated against because of a health condition.

Marco Castro-Bojorquez: I consider my film work to be *contracorriente*, or countercultural. My philosophy is inspired by the efforts of the "Third Cinema," coined by filmmakers and thinkers of the movement of the New Latin American Cinema of the '70s, where the main purpose was to resist, mobilize, agitate, and promote social consciousness to counter the practices of the American film industry, mainly Hollywood. I advocate for the civil and human rights of LGBT people and people living with HIV/ AIDS, as a convener for Venas Abiertas (Open Veins), a network of Latinx immigrant people living with HIV/AIDS in the U.S., as a steering committee member of The U.S. People Living with HIV Caucus, and as a lead organizer with the coalition of Californians for HIV Criminalization Reform. See more about my filmwork at about.me/castro-bojorquez.



An updated annotated bibliography on HIV criminalization was published in August. (An annotated bibliography is a list of citations to books, articles, and documents. Each citation is followed by a brief—usually about 150 words—descriptive and evaluative paragraph, the annotation.) First published in 2012, "Bibliography on Criminalization of HIV Non-Disclosure, Exposure, And Transmission" was curated by Dini Harsono, M.Sc., Assistant Director of the Clinical and Health Services Research (CHSR) Core and coordinator of the Criminalization of HIV Exposure Work Group at CIRA. The document systematically highlights the literature consisting of summaries of criminal laws, empirical research, legal and public health analyses, fact sheets and guidance documents, consensus statements, and other relevant references on criminalization in the context of the United States and Canada. The bibliography is a working document and will be updated periodically. bit.ly/2MP7T8M

ORGANIZATIONS AND RESOURCES ON HIV CRIMINALIZATION:

Center for HIV Law & Policy
hivlawandpolicy.org

HIV Is Not a Crime National Training Academy
hivisnotacrime.com

HV Justice Network
hivjustice.net

Lambda Legal
lambdalegal.org/know-your-rights/article/hiv-criminalization

Positive Women's Network
pwn-usa.org/issues/know-your-rights-guide

POZ magazine
poz.com/criminalization

The Sero Project
seroproject.com

WHAT YOU NEED TO KNOW ABOUT HIV CRIMINALIZATION

HIV-specific criminal charges have been filed in the United States more than 1,500 times since the first HIV-specific laws were introduced in 1986.

Thirty-four states currently have HIV-specific criminal statutes in effect.

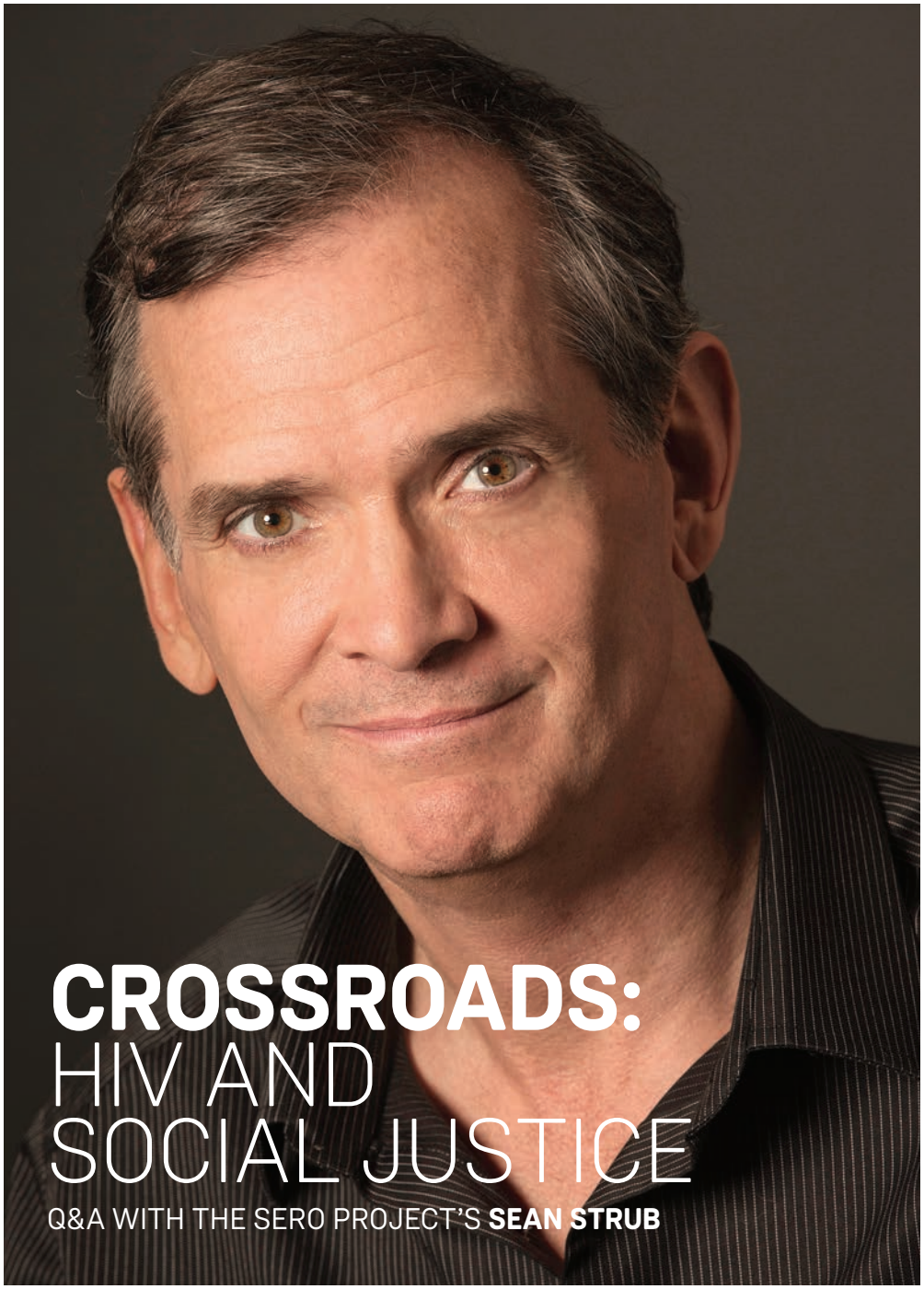
The majority of these laws criminalize HIV non-disclosure, and incarceration for consensual activity if they do not notify their partner of their HIV status. These prosecutions disregard condom use, viral load, or the actual risk of transmission.

Other statutes enhance sentences for crimes relating to sex work, heightening misdemeanors to felony status when the defendant is HIV-positive—even in solicitation cases where there is no allegation of sexual activity.

Many of these HIV-specific laws were passed in the early years of the epidemic, and ignore current scientific knowledge about the effectiveness of condoms, antitretrovals, and pre-exposure prophylaxis (PrEP) for preventing the transmission of HIV.

25 states criminalize one or more behaviors that pose low or negligible risk for HIV transmission, such as biting or spitting. Spit does not transmit HIV.

Even states without HIV-specific statutes have prosecuted people living with HIV, charging them with aggravated assault, attempted murder, and bioterrorism.



CROSSROADS: HIV AND SOCIAL JUSTICE

Q&A WITH THE SERO PROJECT'S **SEAN STRUB**

AS AN EARLY AIDS ACTIVIST and a long-term survivor, Sean Strub has taken on many roles throughout the HIV epidemic. In 1990, he became the first candidate openly living with HIV to run for Congress. He was among the ACT UP protesters in 1992 who placed a giant condom over the home of then-Republican U.S. Senator Jesse Helms. Strub founded *POZ* magazine (like POSITIVELY AWARE, published for people living with HIV), and produced an off-Broadway play, *The Night Larry Kramer Kissed Me*. At 60, he is executive director of The Sero Project, a nationwide network of people living with HIV and their allies, combatting stigma and social injustice. Strub recently took time out to talk about HIV criminalization, and what it's like to be mayor of a Pennsylvania town, population 974.

How did the Sero Project come about?

I HAVE BEEN FOCUSED ON helping to support and strengthen PLHIV networks for many years. It was clear that the voices of people living with HIV [PLHIV] were what would drive the anti-criminalization movement. When NAPWA [National Association of People With AIDS] shut down, it seemed like a good time to start a network focused on supporting other networks and combatting criminalization. That's what Sero does. Our entire board is comprised of PLHIV as is most of our staff.

How has HIV stigma changed over the last 30 years, and what is the link between stigma and criminalization?

MANY PEOPLE REMEMBER when one had to wear a spacesuit to visit someone with HIV in the hospital, or when people were afraid to shake hands with someone with HIV or go to a gay restaurant or whatever. Since most people know more about HIV today, and that fear of casual contagion isn't as bad, people think stigma has lessened.

But stigma, as experienced by the stigmatized, is about much more than fear of casual contagion. It is about having our moral worth judged when someone finds out we have HIV, about being marginalized and "othered," having our words discounted before they are even spoken. By those measures, stigma is worse today than ever before.

We don't have a broad LGBT and HIV community that recognizes the epidemic as a collective responsibility, as we once did. HIV is no longer a fashionable cause. It can no longer be seen in singular terms and therefore divorced from the intersecting realities of racism, homophobia, sexphobia, poverty, addiction, mental illness,

PHOTO COURTESY OF SEAN STRUB

homelessness, and other factors that drive the epidemic. Very important, a diagnosis is much more isolating today.

That's partly because those newly diagnosed can choose to keep it a secret; they don't have to assume that others will ultimately find out because they will lose weight or show other symptoms. Years ago, when diagnosed, one worried about survival, not the long-term impact on one's career. That isolation denies a person of peer support, becoming part of a community, and fuels loneliness.

What was your biggest takeaway from the HIV Is Not a Crime 3 conference in Indianapolis in June?

THE MOVEMENT TO END HIV criminalization is growing rapidly and has become a defining cause in HIV policy work. Leaders and agencies who aren't contributing to anti-criminalization work are not serious about addressing stigma, not serious about HIV prevention, and are not serious about the quality of life for and rights of PLHIV.

What I found especially exciting is the huge number of new activists finding their voices through this work, especially young people. I alternate between feeling weird about being one of the oldest in the room—I turned 60 in May—and being so thrilled to see all the new energy, as well as the interest in the history that brought us to this point.

We have seen at the HINAC gatherings how HIV criminalization is a crossroads for work in a wide range of intersecting social justice and human rights movements. The HIV criminalization reform work has created stronger ties with those combatting racism, poverty and mass incarceration, those working for drug and commercial sex policy reform, those fighting for the rights of people of trans experience, immigrants, migrants, and those who are incarcerated.

If there's anyone who thinks of themselves as a "single issue" activist on HIV criminalization, they just don't get what it is that we are trying to accomplish. HIV criminalization is a point of entry issue into radical changes to improve the lives of PLHIV and affected communities. I use the word "radical" intentionally, because the vision we have is very different than the reality so many of us must live, but it is not a fantasy. Even amidst the nightmare of the Trump administration, we are making tremendous progress and laying a strong foundation for change.

What do you see as the biggest challenges or opportunities facing the HIV community that the Sero Project can help address and raise awareness about?

1. HIV service and policy organizations and leadership that talk the talk about PLHIV empowerment but don't walk the walk;

2. Inspiring PLHIV to understand and take hold of the tremendous power they have, as individuals, to affect their lives and the lives of other PLHIV. I think often of the quote sometimes attributed to Harriet Tubman, in reference to her work freeing enslaved people, "I could have saved a thousand more if they had only known they were slaves";

3. Getting those who are newly diagnosed connected to PLHIV social, recreational, educational, and advocacy networks.

How can people get involved or find out more?

GET CONNECTED WITH A PLHIV network [seroproject.com/state-networks] or start one. Sero is glad to provide guidance to anyone interested in starting a network in their community.

What is a normal day for you as mayor of Milford, Pennsylvania?

HAH, EVERY DAY IS DIFFERENT. But I'm usually up around 6 am, do the *New York Times* mini-crossword puzzle on my phone—it's easy, but I keep trying to better my best time, which is 56 seconds—and have my first calls or meetings around 7:30. In a given day, I'm involved with Sero work, obviously, speaking with legislators, activists, and policy leaders. I'm lucky to have a great Sero team, with Cindy Stine here in Milford, Robert Suttle and Ken Pinkela in New York, Tami Haught in Iowa, Kamaria Laffrey in Florida, and Allison Nichol in Washington.

I've also got a great team with my mayoral work in Milford as well, including a supportive borough council and dedicated borough employees and many volunteers. Right now we're updating our comprehensive plan, organizing a big benefit for our garden club, and getting started on a major streetscape improvement project. As mayor, I oversee the police department, which is interesting and sometimes challenging, but has given me a greater appreciation for what community policing can be. One of the first priorities for our new chief was to get a police bicycle so our officers can patrol on bikes. Finally, Xavier Morales, my partner, my sister Megan and I run a small hotel and restaurant in Milford and I spend a lot of time on that as well. It isn't unusual to see me bussing dishes when the restaurant gets unexpectedly slammed or changing light bulbs or doing other maintenance work. Working with my hands at the hotel is therapeutic for me and I enjoy it.

Anything else you'd like people to know about?

ONLY THAT AS AWFUL AND dangerous as the Trump presidency has been, don't personalize our battle too much to being just about the revolting person Donald Trump has shown himself to be. We all want him to go and the sooner the better, but the truth is that he exploited an ugly, racist, dangerous, and greedy undercurrent in the nation that will still be there after he is gone. That doesn't mean everyone who voted for him is all of those things—I know that isn't the case—but it does mean the sentiment, the distorted values, ignorance, and intolerance that elected him isn't going away when he does.

The real change—and I believe the most important work any of us can do—is in our neighborhoods and with our families and friends. It might not be glamorous, but the grassroots—the real grassroots—is where we need to create change, neighbor-to-neighbor. That's how I got elected mayor in a community that also went for Trump.

The kind of change we need in our politics, in our society, and in the world will come from the bottom up, with millions of people working in small ways on their home turf, not from the top down. PA

HIV is no longer a fashionable cause. It can no longer be seen in singular terms and therefore divorced from the intersecting realities of racism, homophobia, sexphobia, poverty, addiction, mental illness, homelessness, and other factors that drive the epidemic.

PRISON HEALTH IS PUBLIC HEALTH

The case for testing and treating hepatitis C in prisons

BY **ANDREW REYNOLDS**

"The degree of civilization in a society can be judged by entering its prisons."

—FYODOR DOSTOYEVSKY

THIS QUOTE from the famous classic Russian novelist of the 1800s can easily be adapted to hepatitis C in the United States today: "The degree of the U.S. commitment to hepatitis C elimination can be judged by its commitment to treating HCV in prisons."

Hepatitis C (HCV) and prisons go hand in hand. The U.S. has the largest population of inmates in the world, with over 2.3 million men, women and transgender persons in jail or prison on any given day (see Box 1). With around 1.5 million people in prisons, the overall HCV prevalence (people infected with HCV) in prisons around 18% (with states ranging from approximately 10% to 41%), estimates of the number of people in prison living with HCV can vary, with 270,000 as the generally accepted number, with some thinking it could be over 500,000. Specific jail numbers are hard to come by, as most jail systems do not screen for HCV or have available data, but it is safe to assume that the percentages in jail are roughly the same as they are in prisons. It's estimated that one-third, or 30%, of people with hepatitis C pass through the criminal justice system each year.

Of the 2.3 million in jail or prison, it's important to keep in mind that most will be released: 95% of state prisoners will return to society. People in jail are typically incarcerated for shorter stays, either awaiting trial or serving sentences for less than a year, with an average stay of 2–5 days. Over 11 million people pass though jail or prison each year in the U.S.

People in prison often have other medical and mental health issues, as well as high rates of drug use and addiction. The sheer numbers of people who pass through the criminal justice system, combined with their high rates of HCV, make prisons an ideal location for preventing, testing, and treating HCV, helping put the U.S. on track to eliminate HCV by 2030 per World Health Organization goal. (A caveat: The best way to keep people who use drugs healthy is to not put them in prison in the first place, but provide them with medical care, harm reduction, and social services on the outside rather than arrest them and put them away.)

MYTH #1:
Prisoners are not worthy of HCV treatment

This argument is sometimes stated outright, but more often than not, it's a quiet assumption that policymakers, prison officials, and the general public have but won't say out loud.

Ironically, people in prisons are the only group in the U.S. who have a constitutional right to healthcare. In a landmark Supreme Court case, *Estelle v. Gamble*, it was ruled that ignoring or denying medical care to an inmate was the equivalent of cruel and unusual punishment. As the ACLU summarizes: "an inmate must rely on prison authorities to treat his [or her] medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or a lingering death."

Beyond the legal rationale for treating HCV in prison, we have a moral one, too: The separation from free society and loss of liberty is the punishment for whatever crime they have been convicted of, and the removal of access to healthcare should not be included in this punishment. A person in prison should have the same rights to access healthcare as she/he would have on the outside.

MYTH #2
We need to focus our treatment efforts on people who aren't in prison

Technically, this isn't a myth: Yes, we do need to get people who aren't in prison treated for HCV. We also need to treat people who *are* in prison. It doesn't have to be one versus the other. We can and should do both.

Guidelines, established by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America, do not distinguish who should be treated based on whether or not they are incarcerated: "Treatment is recommended for all patients with chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy." A recent addition to these guidelines makes clear that people in prison should receive HCV testing, harm reduction and prevention education and support, and linkage to care and treatment, just as people who are not in prison receive.

In order to eliminate HCV, a concerted effort must be made to screen and treat HCV for all those at risk of infection, both those in and out of prisons.

MYTH #3
Prisoners won't manage their HCV properly

This is a myth based on old HCV regimens—pegylated interferon and ribavirin—that were very difficult to take. The treatment combination was very long, lasting 48 weeks, required an injection once per week, and had severe side effects. Active drug use, co-occurring medical or mental health illness, side effects,

2.3 MILLION
people in the U.S. are in jail or prison
PRISON POLICY INITIATIVE 2018

11 MILLION
people pass through U.S. jails and prisons each year
PRISON POLICY INITIATIVE 2018

ISTOCK

THE WAR ON DRUGS, PRISONS AND HEPATITIS C:

We can't incarcerate our way out of this problem

■ **Social policy decisions** can have far-reaching effects and unintended consequences. Rather than taking a public health approach to address illegal drug use, the U.S. chose to deal with the issue by declaring a "war on drugs" that began in the 1970s. In choosing to incarcerate drug users rather than provide drug treatment and other harm reduction interventions, arrest rates soared, and the U.S. prison population exploded in the decades to follow.

■ **Injection drug use** is the most common mode of HCV transmission, accounting for approximately 70% of new infections. People who inject drugs (PWID) are also arrested and incarcerated at rates well above the average.

■ **Initiated by** President Richard Nixon, the war on drugs is now nearly 50 years old, and has not resulted in reductions in drug use, but rather, increased our country's prison population, disproportionately targeted people of color (especially African Americans) and widened health disparities in infectious diseases like HIV and HCV.

■ **A public health approach,** where we decriminalize personal drug use, expand harm reduction programs like syringe access services and safe consumption spaces, and replace incarceration with drug treatment and medication-assisted therapy, would be a far more effective approach to drug use.

and length of treatment all posed significant barriers to treating HCV in prisons and jails. That said, even in the days of interferon, people in prison who received treatment were cured at rates similar to those on the outside.

In today's HCV treatment landscape, newer medications known as direct-acting antivirals (DAAs) have a shorter treatment duration (8–12 weeks), have fewer side effects, and have a cure rate of over 95%. They are safe and effective for people in prison to take, and the shorter durations make them ideal for people in jail to take as well. There is no medical or clinical reason to deny treatment to people in jails or prisons.

MYTH #4

Inmates will get reinfected

This one is a little more complicated: People living in prison are at greater risk of HCV reinfection, both inside prison walls and upon release, but that's mainly because they do not have access to all the things that we know can reduce reinfection. All the risks that exist outside of prison—sharing injection equipment and condomless anal sex—also happen within prison walls. The major difference is that people in prisons have no access to sterile syringes and injection equipment or other harm reduction services. In the U.S., there are no prisons or jails that offer syringe exchange services and safe injection supplies, none that offer safer tattooing options, and very few that offer medication-assisted therapy. Related to myths 1 and 2, there are few options for HCV treatment, and the more people who get treated in prisons and jails, the less likely reinfection will occur.

MYTH #5

It's too expensive to treat people in prison

This is the same myth we've heard since the DAAs were first used in late 2013. It is true that HCV treatment can be expensive. The high cost of prescription drugs in the U.S. is a problem beyond HCV, but HCV drugs have attracted some of the most media attention, as well as the attention of insurance carriers, both private and public, including prisons.

That said, the days of the $1,000 pill are well behind us. With several medications on the market and competition, as well as lower negotiated drug prices among several pharmaceutical companies and insurance carriers, both public and private, the cost of medications has dropped dramatically.

At current prices, HCV treatment is cost-effective. It is true that there will be an initial jump in spending to pay for the testing and treatment of people in prison, but this short-term cost is more than made up for in the reduction of new infections, prevention of advanced liver disease such as cirrhosis, liver cancer, or liver failure, and a reduction in HCV liver-related deaths. Patients with HCV who are cured have improved quality of life and utilize fewer health resources. Finally, when prisoners are cured inside of prison, there are benefits to the larger community, as there would be fewer new infections there too, and less cost for medical care upon release.

BEYOND THE MYTHS:

Doing what's right

Anne Spaulding and colleagues from the Rollins School of Public Health, Emory University, have suggested an "opt-out" model of HCV screening in U.S. jails. An opt-out system automatically includes a test among a battery of routine tests done with a general consent, while still allowing a person to refuse the test. In a brief model put forth in the *New England Journal of Medicine*, Spaulding states that if there are 1 million people with HCV in jails, and 70% are offered an HCV test and 70% of those accept the offer, then 500,000 new HCV infections can be uncovered in the first year alone (Spaulding 2012). The public health impact of jail screening can have wide-ranging impacts on the health of the community as a whole.

Once new HCV infections have been identified in correctional settings, the need for support, education, care, and treatment is the responsibility of the system, as referenced above. Hepatitis C care and treatment in the DAA era is easier than ever, but it can still be very complicated and may require the work of specialists who may not be readily available in a correctional setting.

That said, successful treatment of people in corrections is possible. Today's HCV treatments are shorter, easier to take with fewer side effects, and more effective in curing people. This not only increases the options for successful treatment of people in prison, but it also opens the door for people serving shorter sentences in jails.

PRIMARY CARE PROVIDERS will play a central role in treating HCV, in both community and in correctional settings, but they will need support and training to do so. To address this need, the University of New Mexico (UNM) initiated "The Extension for Community Healthcare Outcomes" (Project ECHO) to train and improve the capacity of primary care providers in rural areas and prisons to manage HCV. They employ telehealth technology, case-based training, and ongoing training to medical providers. This evidence-based model has been shown to improve the care and treatment, and consequently the cure rates, of patients in correctional settings, and the expansion of this model can serve the treatment needs of people in jails and prisons across the country.

In addition to supporting the training of medical providers, there is a strong need to provide patient support and education in jails

and prisons. Peer support models have been shown to be effective interventions for patient support. The Centerforce peer health model, "Peer Health Education Program (PHEP)," was identified by the CDC in 2009 as a model program in HCV service delivery in prison settings. PHEP develops a variety of educational materials, presentations, and training, as well as videos and support group guides to HCV prevention and care. They train peer educators to hold workshops, provide one-on-one counseling, and outreach to prisoners to raise awareness. Similarly, the New Mexico Department of Corrections partners with UNM's Project ECHO and uses telehealth to train and develop peer educators to both provide health education and support for people living with HCV, but also to prepare for a career as a community health educator upon release from prison.

Soon, we'll have a real-world example of the impact of treating all people in prison for HCV. California has embarked on such a program. The state's 2018 budget allocates $105.8 million per year for three years to pay for treatment of all HCV-infected prisoners in the state. In the first year, they will focus on treating the sickest inmates—those with advanced liver scarring and cirrhosis—while scaling up their treatment programs and capacity. In years two and three, all remaining HCV-infected inmates will be treated and cured, with ongoing screening and monitoring for new infections, reinfections, and other liver-related medical issues.

670 out of every 100,000
people in the U.S. are incarcerated
SENTENCING PROJECT 2018

36.5%
of those in state and federal prisons are African American men
SENTENCING PROJECT 2013

Conclusions

IDEALLY, the U.S. would not have the world's largest prison system with epidemic levels of HCV, and have a society where we are able to screen, care for, and treat HCV patients before they enter prison. Until then, we are legally and morally obligated to take care of prisoners' HCV screening, prevention, and treatment needs. With new testing technologies, improved treatment regimens, and innovative, evidence-based harm reduction interventions, we have the means at our disposal. We need to dispel the myths that serve as barriers to HCV care and treatment behind bars, and shift both public policy and political will that will lead to dramatic implications for both prison and public health. As researchers state: ..."we can help to change the perception of the HCV epidemic in the criminal justice system, transforming it from a legal liability to a critical opportunity to change the course of HCV in the United States." PA

ANDREW REYNOLDS, who compiles the POSITIVELY AWARE and Project Inform Annual Hepatitis B and C Drug Guide, is the Hepatitis C and Harm Reduction Manager at Project Inform, and facilitates several HCV support groups in the San Francisco Bay Area.

ISTOCKPHOTO

HCV RISKS IN JAILS AND PRISONS

MOST INMATES with HCV enter jails or prisons already infected with the disease, but there are a number of risk factors that, when combined with the closed setting and poor access to drug treatment and harm reduction services, may exacerbate risk and lead to new infections among previously HCV-negative persons.

These risk factors include the following:

- **Sharing of syringes and other injecting equipment**
- **Sharing of intranasal snorting equipment (straws, Visine bottles) for non-injectable drugs**
- **Limited access to drug treatment, including medication-assisted therapy**
- **Limited access to HCV treatment (treatment as prevention)**
- **Unsterile tattooing and piercing**
- **Condomless sex among inmates living with HIV (HIV-positive individuals are -at greater risk of sexual transmission of HCV)**

Although needle and syringe access programs (SAPs) remain a controversial issue in many parts of the U.S., it is well established that these programs are an effective, evidence-based intervention for preventing HIV and HCV infections in people who inject drugs (PWIDs). If PWIDs are incarcerated, they then no longer have access to these prevention tools. Internationally, however, prison and public health officials have introduced prison-based needle exchange programs that have had similar benefits as they do on the outside. Over 60 prisons in 10 countries operate SAPs in prisons; research and evaluation of these programs have found that needle-sharing is decreased, HIV infections are reduced, and there was no increased injection drug use or increases in levels of drug use. In over 30 years of operation, there have been no reports of syringes used as weapons.

POSITIVELY AWARE

For pagination purposes, this page has been intentionally left blank.

LEARNING TO STAY 2GETHER

How to have a good relationship as a male couple

BY **ENID VÁZQUEZ**

ISTOCKPHOTO

Ah, love. So much heartache. What's the secret to a good relationship?

More than a decade into HIV prevention work, Michael Newcomb and his colleagues found that romantic relationships among gay men were actually driving infections. Not Grindr, not MISTER, not gay bars. It seemed strange, but other researchers were finding the same thing.

Yet in his work, what gay men told Newcomb they wanted was to learn how to get and keep a boyfriend, and have a healthy relationship, not just hear about HIV.

What's a smart researcher to do? Combine the interests of the men with the imperatives of HIV prevention and—*voilà*! The 2GETHER Couples Project study was born. Funded by the National Institutes of Health, the program helps men, whether HIV positive or negative, work on their relationship together, both as a couple and in a group with other male couples. It helps them learn skills for intimacy, enjoy healthy sexuality, and work through a relationship agreement to guide their future.

"We had observed in our studies that the most common predictor of whether or not someone becomes HIV positive is being in a serious romantic relationship," said Newcomb, PhD, Assistant Professor, the Institute for Sexual and Gender Minority Health and Wellbeing at Northwestern University's Feinberg School of Medicine, in Chicago. "At first when we first started to see this it was very surprising because the predominant idea as to where most HIV infections were coming from was from hooking up; people that you met at a bar or online or something like that, people you don't know. The truth is, our prevention message got across that if you meet somebody, if you don't know anything about them, that you should be more careful with those partners and use condoms or other prevention methods. So, people were doing that very well.

"OUR OTHER MESSAGE at the time was if you are in a relationship, then that's a place where you can let your guard down, enjoy sex without a condom. Unfortunately, what often happens is that, particularly among young people, many if not most young people who are HIV-positive don't know that they are HIV-positive, because they haven't been tested recently," explained Newcomb. "What that leads to, when they get into a relationship and they stop using condoms with their partner, is the potential for HIV transmission. So we started to think, 'Wow, what is the prevention message here?' It's not easy to convince couples to use condoms, because one of the benefits of being in a relationship in terms of sexual pleasure and intimacy is having sex without a condom. That's not a great prevention message." >>

'There are so many things that can't be answered by a 15-minute doctor's visit. We need behavioral approaches to help increase the uptake of our biomedical interventions.'

There's a control arm to the study, providing couples in that part of the study participation in a program that's well-established in showing improvements in people's mental health and wellbeing. So whether couples are randomized to the 2GETHER program or its control arm, they are receiving the same amount of time and attention. Yes, the study is aimed at showing reductions in new HIV infections and STIs.

"I love the fact that these are programs that are open to anyone regardless of HIV status," said Jim Carey, MPH, the 2GETHER lead facilitator and a Research Project Coordinator at the Institute. "A lot of RCTs [randomized controlled trials, or studies] have been focused on HIV-negative people and how to help them stay negative, which is fantastic, but I feel like that's leaving an entire piece of the population out of the equation. So the fact that people can participate regardless of HIV status, regardless of how they identify their relationship—whether they are open or not or somewhere in-between—I think it's a more comprehensive approach to meeting the population where they are."

2GETHER REVIEWS the current biomedical prevention methods used against HIV, most specifically PrEP use by men who are HIV-negative, and the use of TasP (treatment as prevention) by men living with HIV.

"We're integrating both primary and secondary HIV prevention, so prevention for negatives and positives into the same program," said Newcomb. "It's so important particularly in the context of the big shift to biomedical prevention strategies. With all that we know now with the effectiveness of PrEP and also the effectiveness of viral suppression on reducing HIV transmission, we're at the point where we can talk to everybody at the same time, rather than segmenting prevention into either prevention for negatives or prevention for positives."

This also means they get to talk to everyone about adherence to medication, taking the pressure off of those living with the virus. "That's really what's the same in the HIV field as it is in every other health condition—that there's no magic bullet to fix things," said Newcomb. "We can't just provide someone with a medication and assume that it will go perfectly after that. In order for medical interventions to be effective they need to be paired, for many people, with behavioral interventions as well that address those barriers. It's about things like stigma, but it's also addressing access to resources, access to PrEP, improving people's knowledge about what PrEP actually does. There are so many things that can't be answered by a 15-minute doctor's visit. We need behavioral approaches to help increase the uptake of our biomedical interventions."

THE PROGRAM FINDS that among other things, couples come in thinking that they know how to communicate well with one another—and then discover that they don't.

"The truth is that people are very different in the way that they communicate. People can be effective at communicating if they are quiet, if they are very verbose—you can be effective no matter what your communication style is," said Newcomb. "We just try to improve the manner in which each couple is communicating based on what they bring to the session. It's the same set of skills, just applied to each couple's individual needs.

"Ultimately, at the end of the program, we help the couples build what we call a relationship agreement. That agreement details first the conditions under which it's acceptable to have sexual partners outside of the relationship—if at all—and then, depending on the agreement that they have with their partner, we layer on top of that specific prevention methods that are tailored to the agreement that they have," Newcomb said. "So those prevention methods could be using PrEP. If folks are HIV positive, then reducing viral load so that people are virally suppressed, as well as things like condom use and more frequent use of HIV and STI testing and things like that."

FOR WHATEVER couples need that is outside the realm of the project, they receive referrals, such as for HIV testing or PrEP prescriptions. Study staff finds that the men are happy to receive information about PrEP and referrals for other services.

Carey recalls the day when, as an undergrad, he made a presentation on HIV prevention that included a large bin of condoms for student use. He was happy to find the bin empty the next day—until someone told him another professor had thrown the condoms away so that students wouldn't be tempted into having sex.

"People are not having sex because they have a condom," said Carey. "You're giving them the option of using a condom if they do have sex. I always compare the stigma conversation around PrEP to the exact same conversation when birth control pills were released in the '60s. The argument back then was that, It could make women promiscuous! And, It could make sex about pleasure! And that, They're going to have more partners! It actually turned out not to be case. It just gave them more options. So I present PrEP much the same way, especially considering it's mainly more higher-risk individuals that are likely to take it. It's actually designed for that population. Most of the time they're probably not using any other prevention method to begin with, so we should give them more tools to put in their toolbox. It's like a lifejacket. You could wear a lifejacket to prevent anything from happening or you could say, 'Oh, if you fall in the water, that's your own problem. You'll just have to deal with it.' That makes no sense whatsoever."

Added Newcomb, "So many people don't think they're at risk." He knows, however, that HIV prevention education may change community standards—what people believe is acceptable and expected.

"We know norms have a big influence on people's behavior," Newcomb said. "It's easier to play the blame game and point the finger at someone else. The truth is that norms have an influence on older people as well as younger people." PA

National videoconferencing for love and wellness: The 2GETHER program has a national component available to gay male couples across the country, operating via videoconferencing. For more information, email the team at 2gether@northwestern.edu or text 2GETHER to 773-340-9825. Follow 2GETHER Couples Project on both Facebook and Instagram.

For pagination purposes, this page has been intentionally left blank.

Howling Out art through eyes of love

Artist Michael Payne's work gets published at AIDS 2018

BY ENID VÁZQUEZ

An international conference provides people around the world with the opportunity to meet and share important ideas and support. This year, the *HIV Howler* was created to bring art with a message, created by people living with the virus, to the International AIDS Conference in the form of a newspaper. Its motto is "Transmitting Art and Activism."

"Artists have and continue to play a fundamental role in shaping broader societal understandings of HIV and working within the communities that are most impacted by the virus, such as people who use drugs, sex workers, people of color, indigenous peoples, trans folks, and LGBQ+ people," notes the project's call for art submissions.

Michael Payne, a member of the art therapy group at TPAN (publisher of POSITIVELY AWARE), submitted works to the *HIV Howler* for consideration. Three of his paintings, focusing on pleasure and criminalization, were accepted for publication.

"Blown Away," "Erotica," and "Eyes of Hatred" represent the development of both his art and his politics.

Payne spent two years at a liberal arts college, but after losing his job, became homeless. After a week of hitting the pavement looking for work, he received two full-time job offers. "Young people need to look at that. They're so used to 'give me' and 'I'll just go home and live with my parents,' " he said.

He was estranged from his family. Early on, his parents discouraged his dreams of becoming an artist. While he now believes that they were trying to protect him, they in fact destroyed his confidence. When hanging out with friends, more than one person told him he was like "a scared little boy." He began to change when a friend said, "Michael, you're not a little boy anymore." Still, he had gone into music as a young adult and had a song stolen by an agent. He then gave up all creativity and spiraled even deeper into depression.

"I don't really fit in the profile of homelessness," Payne said. ""I came from an upper middle class black family from a very nice neighborhood. My family was full of high achievers. When I was out there I found that there were a lot of people like me.

"It's just like drugs," he continued. "People have a misconception of what that means and who those people are. They think that they are born losers. They don't realize that there are movie stars who made millions of dollars who've become homeless."

PAYNE SAID HIS WORK has turned more political of late, particularly after the 2016 U.S. presidential election. He said some of that work was so angry, he threw it in the garbage.

He was thrilled at having his artwork accepted for the *HIV Howler*. "For someone who doesn't even know you to look at your work and say 'I like it,' that is so huge to me. You never know what kind of opportunities will pop up when you're doing this kind of thing."

Although he had stopped creating art more than a decade ago, he kept a closet full of his work. But he was reborn as an artist after attending art sessions at TPAN. "To have this happen this late in my life, to me it's God saying 'I had your back all along.' I do believe in God. I think He's doing this as a bucket list [fulfillment] sort of thing."

Payne gave up explaining his artwork a long time ago, when he saw that others were judging the work from their own perspectives. To him, that was fine, whether they liked it or not. For the pieces accepted by *HIV Howler*, however, he was happy to elaborate.

"Blown Away" represents illicit drug use, which led to an episode of homelessness in his life. "This to me looks like madness. That's what the drugs mean to me, it's total chaos. I put Superman in there because when you're on drugs you feel like Superman."

"Erotica" is perhaps the strangest piece he's ever produced. Filled with orgiastic scenes from a freer time decades ago—not all of which he engaged in himself—it shocks those who know him. Those who don't have reacted with approval.

Which is strange to him because it's a piece he never wanted to show, and sent to the artist in charge of the art therapy group just for fun. Jessie Mott, who led TPAN's art therapy group until recently, responded that he should exhibit it at the group's annual art show at Las Manos Gallery in the Chicago's Andersonville neighborhood, near TPAN.

"I said, 'Jessie, no!' " Payne recalled.

"He was nervous and thought it was too risqué," said Mott, "but of course, that's the kind of work I love the most. [Laughs.] I said, 'No, this is going to be big.' " She sees the painting as "whimsical and yet really sensuous at the same time."

"Jessie told me, 'Just do it [the exhibit]. Artists are supposed to do in-your-face stuff.' I thought about that," said Payne. "I have to stop being afraid to express my art, whatever it is. If people get offended by it, I have to say that's probably a good thing. Because it's supposed to be provocative. If it didn't offend you, it's not powerful enough."

"Eyes of Hatred" brings out much more in Payne. While the eyes of the Klansman peep through the holes in his sheet, the eyes of the black man and of the white policeman are blocked by sunglasses. The work holds different meanings for Payne.

HE OBSERVES THAT people use sunglasses, even on a cloudy day. "So my thought is ... people don't want to be seen or maybe they're hiding something." He's noticed that individuals caught on video making racist rants that went viral over the summer were also wearing sunglasses. He thought it was interesting that they didn't bother to remove the glasses.

"Maybe they're ashamed. I'm not a psychologist or anything, but I wonder if part of that is, 'Even though I tell you I hate you, I know when I'm alone, when I go to sleep at night, that it's not good to harbor this hatred, but I can't help it.' You don't want to look a person in the eye when you're filled with that much hatred. It can't be a happy thing. It's how we hide our hatred too, and how we may not be proud of it. And I think everybody is capable of hatred. I don't care what color you are.

"Police use the sunglasses, in my mind, because it's intimidation. They don't want you to see whether they're looking at you," he said.

He remembers walking out of TPAN one day and the eyes of another black man looking at him with hatred. He thought that with TPAN being known as a place serving gay people or people living with HIV, or both, the man objected to his being.

'I think people have become too complacent and I want people to get upset, get angry, become active and do something about it. Don't just look at a painting and look remorseful.'

PAYNE'S 'EYES OF HATRED'

"You can just see hatred in somebody's eyes. They say when you look in a person's eyes, they either smile or they frown. When you look in the eyes of a person who's nice, there's a warmth. When you look in the eyes of hatred, there's a coldness. You know if a car ran over a puppy dog, they would look like that. 'I don't care. I don't feel nothing about it.' So people like that, I find them really disturbing. I'm just at a point where I'd like them to just stay away from me. I just want to be safe."

The supposed "victim," however, is also wearing sunglasses in the painting. "I originally was going to have him as just the innocent victim. But then I thought about how I walked out of here and had this black guy look at me in just a hateful way. It can be an equal opportunity. Black people have been largely victimized. But there are black people who are full of hatred too, for gay people. Me being black and gay, trust me, I've been around enough black people that hate gay people and hate *me* because I'm gay. That's why I decided to include a black person in there. And I think that's fair. [Pause] You can't say one race has a lock on hatred, though white people probably take the cake."

But there's much more to his perception of racism.

"WHEN PEOPLE SAY racist things, I try to play devil's advocate. Can people change? George Wallace [an Alabama governor in the 1960s and '70s who was an outspoken segregationist and racist] atoned at the end of his life. That's something that you have to process over time. I've been in the car with my father when the traffic gets bad and he says. 'Look at that stupid so-and-so.' It was just the anger in the moment. When you're angry with someone you pick a word that hurts them.

"I'm not perfect either. I have had periods in my life when I got angry at someone and used a racial slur. *I've done it.* And I'm not proud of it. We're all human beings. As long as you are aware that—that's ... not ... good. As long as it bothers your conscience, then you are redeemable. But when you do it and think 'I've done nothing wrong,' that some Nazis are good, that's disturbing. That's Hitler-like."

He said that with a greater bent to being more political in his art, his work is meant to be disturbing. "I think people have become too complacent and I want people to get upset, get angry, become active and do something about it. Don't just look at a painting and look remorseful. 'I don't want to think about that.' You need to think about it."

Said Jessie Mott, "To have that kind of reach, at the conference, is going to be just wild."

She said that from the start of the art therapy group, Payne was committed to his art and obviously very talented. He was also an unofficial leader of the group. "He's kind. He's really helpful to the other people. He has lots of empathy."

"Ultimately, the group is about creating social connections and building a community," said Mott. "We check in and we talk about their week. But there's lots of joking and laughter. It's like a family, especially for the people who come in week after week. Everyone can find two hours of peace and creativity that week. For some people, it's their only two hours out of the house. You come in and play. Mostly it's about a safe place to be creative."

PAYNE'S CONFIDENCE is really showing through now, said Mott. "He has so much work and he gets a lot of response."

"He's a real survivor," Mott said. "He's a real joy to be around."

The *HIV Howler*, funded in part by the Toronto Arts Council, was envisioned by queer couple and project collaborators Anthea Black and Jessica Whitebread, who are based in that city. This is a limited edition project they see as allowing art to be easily distributed. "We loved his [Payne's] vibrant illustrative works," said Black via e-mail. "We felt they could be interpreted to show a lot of important ideas that impact people living with HIV, and also the international advisory committee was very interested in showing drawings, paintings, and other creative works by HIV-positive artists and folks who might not be getting mainstream recognition in the art world."

Forty artists publishing in five languages are represented in the *HIV Howler* editions. They include an "in conversation" piece between New York mixed-media artist Frederick Weston and Nancer Lemoins of San Francisco, who does printmaking and bookmaking as well as drawings and paintings; writing by Ed Moreno of Brazil; photography by Kairon Liu of Taiwan; paintings by Manuel Solano of Mexico; and drawings by L'Orangelis Thomas of Puerto Rico. PA

COURTESY OF MICHAEL PAYNE

MONDAY'S COMMUNITY MARCH THROUGH AMSTERDAM.

MUSINGS FROM AMSTERDAM

A brief recap of my week at AIDS 2018

BY **JEFF BERRY** @PAeditor

IN A WHIRLWIND WEEK of workshops, demonstrations, presentations, and meetings, this year's international AIDS conference in Amsterdam brought home the fact that while we have made incredible progress and much has changed since the conference was first held here in 1992, including the recent approval of PrEP by the Dutch government, incredible challenges remain—since 2010 HIV infections have increased by 30% in Eastern Europe, largely due to intravenous drug use.

There was a touching moment in the opening session when Dr. Joep Lange, his partner Jacqueline van Tongeren, and four others who were headed to the 2014 conference were remembered and honored. They were all aboard Malaysian Airlines flight 17 on that fateful day in 2014 when it was shot down and 298 lives were lost. The conference co-chair Peter Reiss became choked up as he was talking about his friends who were murdered on the flight, and I and thousands of others were in tears as well. It was because of a conversation with Joep before he was killed that they decided to bring the conference back to Amsterdam after 26 years.

Go to the online program at AIDS2018.org for webcasts, slides, and rapporteur summaries of the conference. Videos are also available on the IAS YouTube channel at youtube.com/iasaidsconference.

MARCH: @MATTHIJS IMMINK-IAS · PHOTOS THIS PAGE: JEFF BERRY

▶ U Equals U

ONE OF THE most notable things for me about this conference was the prominence of U=U (undetectable equals untransmittable), with an all-day pre-conference workshop, several sessions, and endorsements from numerous speakers, including Dr. Tony Fauci of NIAID, Alison Rodger during her presentation of the landmark PARTNERS 2 study results showing zero new infections of the partners of gay men on effective treatment, and Pietro Vernazza, co-author of the Swiss Statement which laid the groundwork for Prevention Access Campaign's empowering message that people who are on effective HIV therapy do not transmit the virus.

During the workshop William Matovu of Uganda's Love to Love, a partner of the campaign, spoke about the factors that hinder spreading the message of U=U in Uganda, including HIV colonialism, ignorance, and the lack of financial support for and the negligence of people living with HIV. Matovu, who was shunned by his family after testing HIV positive as a young boy, now advocates for the rights of orphans and other vulnerable youth by creating opportunities for them in their own communities. Innovative campaigns from around the globe were highlighted throughout the day, including those from Russia, Belize, Australia, and the U.K., just to name a few. Dr. Alex Schneider is a German-Russian activist living with HIV and co-creator of a mobile app designed to help improve adherence called Life4me+ (available on Google Play or the App Store). He pointed out that U=U is about "getting people to start to think about the science, and not the fear."

Pietro Vernazza was presented with an award for his early groundbreaking work on the Swiss Statement, and was visibly moved by the standing ovation given by those in the room. "I'm shocked at what is going on here, but it's always been about emotions," said Vernazza, fighting back tears.

Nic Holas, co-founder of The Institute of Many in Melbourne, Australia, ended his presentation with a rousing call to action and admonition of those in power who are controlling the message. "It's vital that campaigns like U=U keep centering the voices of PLHIV and ensure we are not erased, as dynamic new prevention technologies that reach HIV-negative people are increasingly rolled out as the silvery-blue bullet many in the global HIV response have been seeking...

"Whatever you call it: U=U,

TOP: MATOVU, OF UGANDA'S LOVE TO LOVE ORGANIZATION.
MIDDLE: VERNAZZA IS MOVED BY A STANDING OVATION.
ABOVE: RODGER DISCUSSES PARTNER 2 STUDY RESULTS.

STEVE DEEKS (LEFT) LOOKS ON AS CLARK HAWLEY TALKS ABOUT PARTICIPATING IN THE CURE STUDY.

UVL, TasP, call it loud and proud. It is not enough to end the HIV epidemic with PrEP and leave us isolated, criminalized, and stigmatized. No longer can we accept gatekeeping from CEOs and board chairs of PLHIV and AIDS organizations. No longer can we allow this life-changing, life-saving information to be withheld from us.

"*Zero* risk equals *zero* excuses. If you are part of an organization that is sitting on this information, you are killing us."

▶ HIV cure

THE HIV CURE COMMUNITY pre-conference workshop took place on Saturday, two days before the official conference opening. See Karine Dube's blog at positivleyaware.com for more about the workshop. One of the highlights for me was getting to hear Clark Hawley, who was featured in the POSITIVELY AWARE Summer 2018 issue on HIV cure, tell his story about how he came to participate in a cure study.

In an interview of Hawley by Dr. Steven Deeks of USCF, who heads up the cure study he is in, Hawley spoke of how after coming out later in life and having gone through a "slut" period, he decided to go on PrEP because he was ready for love. Hawley is thought to be the earliest adult who initiated treatment after being exposed to HIV (probably around 10 days; he was only on PrEP for four days and was immediately put on ART). He now takes two pills a day instead of one, he says. "When you get covered in the magazine as one of the poster boys for HIV, this was not one of the things I aspired to be."

Says Hawley, "If people knew how much the researchers care for study participants, they would be much less fearful [about participating in a cure study]."

In the Wednesday morning plenary session, R. Brad Jones, PhD, of The George Washington University, gave an eloquent overview of HIV cure research, one of the most understandable and entertaining presentations on the topic that I've ever seen. In his talk Jones used the analogy of the story of the little Dutch boy, who spots a leak in the dam and saves his town by plugging it with his finger until help can arrive, to categorize the different cure strategies currently being pursued, either by draining the reservoir (sterilizing cure) or by "reinforcing the dam" (boosting the immune response to HIV, also known as a functional cure).

Jones concluded with an empowering analogy of how past epidemics can sow the seeds for future cures. The Delta 32 mutation that makes cells resistant to HIV, and contributed to the one known cure to date (that of Timothy Ray Brown), came from a past epidemic such as the plague or smallpox, we don't know for sure, said Jones. "But we should also know that the seeds of discovery that we generate in the process [of discovering a cure] will drift into the future and will have positive benefits on human health long after the HIV epidemic is over. That will be the enduring legacy of the special community that we've built—and it will emerge from the altruism of people living with HIV, including those who continue to participate in research after they themselves are healthy. People like [Timothy Ray Brown] and so many of you whom I've had the honor to speak to today."

BE SURE to check out the entire presentation at aids2018.org.

▶ Long-term survivors

"SURVIVOR CONFLICT" was the preferred term used to describe what's often referred to as "survivor's guilt" by a group of women in the U.K., many of who are long-term survivors of HIV. In a poster by University of Greenwich's Jacqui Stevenson and colleagues, 14 women aged over 50 participated in a life story interview. Participants were recruited to reflect the diversity of women living with HIV in the UK, and included:

Five white British women, one white other, one black British woman, and seven black African women. Twelve were aged 50–60, and two aged 60–70. Two bisexual women and one trans woman participated. One woman was diagnosed less than 5 years, three for 6–10 years, one for 11–15 years, two for 16–20 years, two for 21–25 years and five for 26–30 years.

Some of the comments from participants included,

"Maybe we need something new to define this experience of loss of self, loss of future, loss of identity, loss of..."

"I survived something that I wasn't supposed to and I did..., I don't have a problem with the term survivor, but I don't identify with the word guilt, I don't feel guilt."

"...coin that one, survivor conflict"

"I think that's a more, much better descriptive term than the guilt one, because you're right, you do go between..."

"You go between positive and negative feelings, a sense of confusion, a sense of, it's very difficult to make sense of it, or to have a rational, logical, completely like, being very happy about it. I am grateful, on a good day."

Stevenson told POSITIVELY AWARE that women with HIV often feel excluded because they are not a "community" affected by HIV (such as gay

men), so they have to seek out their community.

The study authors concluded that, "Women diagnosed before effective treatment became accessible have unique needs and experiences that are not adequately understood or addressed. Living with HIV is an ongoing, evolving experience that brings challenges that can be hard to reconcile with simple constructs of 'survival.'

"Surviving a terminal diagnosis is an emotional and psychological challenge that for many women is complicated by feelings of gratitude, loss, and fear for the future. Surviving is just the beginning. Living, for decades, with HIV is negotiated with each new milestone reached and the internal and external meaning of HIV changes with time and age. Beyond this is the prospect of ordinary, mundane mortality, and the challenge of reconciling to 'normal' types of dying."

▶ HIV criminalization

THE BEYOND BLAME: HIV Justice Network pre-conference workshop was kicked off by a moving statement from Laela and Naomi Wilding of the Elizabeth Taylor AIDS Foundation about their involvement with HIV decriminalization. Edwin Bernard, Global Coordinator of the HIV Justice Network, led a panel of activists and people who were unjustly incarcerated under HIV criminalization statutes, and highlighted the work that is being done around the globe and some of the success stories in getting statutes changed or removed altogether.

Deon Haywood of Women With A Vision (WWAV) in New Orleans spoke about the horrific laws in place in Louisiana that targeted sex workers, with the end result being that 97% of people on the sex offender registry were black women. "If we are going to change anything, we are going to have to change who runs what," said Haywood. "Sometimes as activists we feel we have to fight for people, but we have to fight for getting them the tools to fight for themselves."

Edwin Cameron, a judge on the Constitutional Court of South Africa and a gay man living with HIV said, "every single person with HIV lives under the terror of irrationality that derives from stigma."

TO VIEW all of the sessions from the day's proceedings go to tiny.cc/hivjustice.

▶ HIV activism

IN A FASCINATING activism session, Robin Gorna of SheDecides in the U.K. stated that the 1992 conference was held in Amsterdam in light of the horrible human rights issues in the U.S., and here we are 26 years later in Amsterdam facing horrible human rights issues again. Eric Sawyer, one of the founders of ACT UP, talked about how the PWA lounges started at the 1992 conference because people were getting on planes with herpes lesions all over their face, thrush in their mouth, KS all over their body, or PCP, and activists went to Jonathan Mann of IAS and demanded a space where they could rest and get food. Kate Thomson of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Switzerland spoke about how there were, and continue to be, other, quieter forms of activism going on at the same time that haven't yet been written about. Activist William Nutland of PrEPster in the U.K. said that in one sense everything has changed, and in another nothing has changed. "We've made great advances in treatment, a pill for prevention, U=U, so we should be dancing in the streets. But looking back, we should be holding our heads in shame at some of the horrible inequities that were happening."

"I make a call to IAS," said Nutland. "Do not go back to Trump's America in 2020!"

▶ #AIDS2020ForAll

AN ALLIANCE of members of United States networks of people living with HIV are calling upon the International AIDS Society to immediately announce their decision to relocate AIDS 2020 outside the U.S. due to the human rights violations of the Trump administration making it unsafe and unethical to hold the conference here in San Francisco and Oakland in 2020.

Activists, advocates, and allies appeared at AIDS 2018 during a conference main floor banner drop and a people's press conference. Hundreds of individuals and organizations have signed on to No AIDS 2020 in Trump's USA.

FOR MORE INFORMATION about the grassroots movement to move the conference out of the U.S. in 2020, go to hivpowershift.wordpress.com.

EDWIN J. BERNARD AND SARAI CHISALA-TEMPELHOFF ADDRESS HIV CRIMINALIZATION.

ALL PHOTOS THIS SPREAD ©STEVE FORREST-WORKERS' PHOTOS-IAS

AID for AIDS

Jesus Aguais of AID For AIDS (AFA) told the U=U audience that his organization has taken $140,000,000 out of the trash. AFA's HIV Medicine Recycling Program recovers unused, unexpired life-saving medication that otherwise would have been wasted and then re-distributes it to those without access in developing countries through the AIDS Treatment Access Program.

Under the current regime in Venezuela people with HIV are dying needlessly. Eighty thousand people in Venezuela need medications; 10,000 have fled to other countries to access treatment. How can you help? If everyone living with HIV in the U.S. would donate their unused medications, says Aguais, thousands of lives would be saved. To donate, go to aidforaids.org.

AMSTERDAM TRAVELOGUE

PHOTOS BY STEVE FORREST-WORKERS' PHOTOS, MATTHIJS IMMINK, AND MARCUS ROSE FOR IAS; AND JEFF BERRY

PARTNER 2 study—Lots of sex, no transmission

BY **ENID VÁZQUEZ** @enidvazquezPA

THE PARTNER 2 study found *zero* transmissions of HIV in 972 male couples where one partner has the virus and the other doesn't, despite 75,000 acts of condomless sex acts and no use of PrEP or PEP. The men living with HIV all had undetectable viral load.

The study team wanted to expand on the findings of the PARTNER 1 trial, where most of the couples enrolled were straight. That study also found zero linked transmissions.

"PARTNER 2 provides a similar level of confidence for gay men as for heterosexual couples in PARTNER 1," wrote lead author Alison J. Rodger, MD, of the University College London and colleagues in their conclusion.

"I think it's very clear, the time for excuses is over," she said during her presentation. "If you're on suppressive therapy, you're sexually uninfectious."

MORE FROM ENID:

▶ On-demand PrEP succeeds

VIVE LA FRANCE! The ANRS Prevenir community-based study, which took place in the Paris area, found no HIV transmission in men using either PrEP or on-demand PrEP in sex with other men. PrEP prevents HIV. The Prevenir (or "prevent") trial built on the international IPERGAY study that also found successful results with on-demand PrEP in men who have sex with men.

At this time, PrEP requires a daily pill of Truvada. The on-demand PrEP used in this study consisted of:

- two pills of Truvada within 24 to 2 hours before first sexual intercourse, then
- one Truvada pill every 24 hours during the period of sexual activity, with
- one Truvada pill after the last sexual intercourse, and one last Truvada pill 24 hours after that.

"On-demand PrEP with TDF/FTC [Truvada] has been recommended as an alternative to daily PrEP for MSM [men who have sex with men] by the European AIDS Clinical Society following the results of clinical studies, but data are limited on real-world experience," the research team noted in their study summary. Nearly 1,500 HIV-negative men enrolled in the study.

"In this ongoing PrEP cohort in the Paris region, enrolling mainly MSM at high risk of HIV acquisition, no breakthrough HIV infection was reported so far with either daily or on-demand PrEP, supporting continuing use of both dosing regimens in their population," they concluded.

▶ PrEP levels with female hormones

TRANSWOMEN WHO USE feminizing hormones have worried about drug interactions with the use of Truvada for PrEP, noted Akarin Hiransuthikul and colleagues of the Thai Red Cross AIDS Research Center. Not for nothing. The team's iFACT study found that the plasma levels of the tenofovir DF (TDF) in Truvada *were* affected by feminizing hormone therapy. Plasma levels of TDF were slightly lower. This suggests that Truvada for PrEP may be less effective for transwomen on the hormone treatment, although Hiransuthikul said the levels were still high enough to be effective for HIV prevention. More research is needed to see if the lower levels are clinically significant.

The hormone levels, on the other hand, were unaffected by the Truvada. *Yay!* Twenty women enrolled in the study.

▶ Juluca 2-year data

VIIV HEALTHCARE REPORTED that, at two years out, the results of switching to Juluca continued to be non-inferior compared to staying on a three- or four-drug regimen.

Juluca was FDA approved earlier this year. It is a two-drug single-tablet regimen of dolutegravir (brand name Tivicay) and rilpivirine (brand name Edurant).

In combined data from the SWORD 1 and SWORD 2 studies, 456 of the 513 individuals (89%) on Juluca continued to have undetectable viral load.

AKARIN HIRANSUTHIKUL, MD

PEDRO CAHN, MD

▶ Two-drug therapy non-inferior to 3-drugs as initial regimen

ON THE COATTAILS of Juluca, Tivicay's maker, ViiV Healthcare, reported more good news with using it as a two-drug regimen, combined with its Epivir (3TC). (The Edurant in Juluca is from Janssen Pharmaceuticals.)

In two separate studies, GEMINI-1 and GEMINI-2, Tivicay (dolutegravir, or DTG) plus Epivir (3TC) did as well as the combination of dolutegravir plus Truvada (tenofovir DF/FTC).

Pedro Cahn, MD, of Fundacion Huesped in Buenos Aires, and colleagues reported that patients are interested in two-drug regimens to avoid greater drug exposure over their lifelong therapy, as well as minimize potential side effects. "DTG's potency, safety, and resistance barrier make it an optimal core agent for two drugs while 3TC's safety, tolerability, and efficacy make it an attractive partner for initial HIV-1 treatment," they wrote.

After one year in each study, dolutegravir plus 3TC was found to be non-inferior to dolutegravir plus Truvada. In the participants taking the two-drug regimen, 91% (655 out of 716) had undetectable viral load, compared with 93% (669 out of 717) of those taking the three-drug regimen.

There were more than 700 persons in each study, all taking HIV medication for the first time. More than 20% of them started out with a high viral

HIRANSUTHIKUL: @ROB HUIBERS-IAS

load of greater than 100,000 copies per mL. There were more drug-related adverse events with dolutegravir plus Truvada, as to be expected due to the TDF it contains.

▶ Doravirine update

MERCK UPDATED its 48-week data with doravirine to 96 weeks, from the DRIVE-FORWARD study.

Doravirine continued to show non-inferiority to Norvir-boosted Prezista. Both drugs were taken along with either Epzicom or Truvada.

At 96 weeks, 73% of the doravirine group had undetectable viral load compared with 66% of the boosted Prezista group. The average CD4 T-cell count increase was 224 for the doravirine group and 207 for the Prezista group. The 766 participants in the DRIVE-FORWARD study were all taking HIV treatment for the first time.

Side effects in the doravirine arm of the study included diarrhea (17%), nausea (12%), headache (15%), and upper respiratory tract infections (13%). These rates were about the same for the Prezista group.

There was, however, a statistically significant increase in LDL cholesterol and triglycerides with Norvir-boosted Prezista. Norvir is known to increase these levels, even at lower booster doses.

Doravirine is an NNRTI medication (non-nucleoside reverse transcriptase inhibitor). The FDA has accepted a New Drug Application (NDA) for both doravirine and a doravirine single-tablet regimen (combining it with Epivir and tenofovir DF). An FDA decision is expected soon.

▶ Dolutegravir in pregnancy

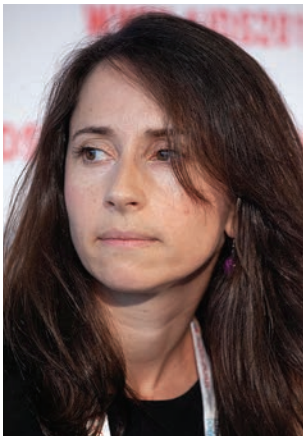
DESPITE LOW EXPOSURE levels of dolutegravir (DTG) in pregnant women living with HIV, the medication managed to bring their viral load down rapidly. That's good news.

The DolPHIN-1 study found a more rapid decrease in viral load in pregnant women taking dolutegravir compared with those taking efavirenz.

The 60 women in the study started HIV therapy in their third trimester. According to the report, starting HIV therapy this late in the game has been associated with an inability to achieve undetectable viral load as well as increased transmission. There were no HIV transmissions in this study.

"DTG transfer across the placenta (122%) and in breast milk (3%) coupled with delayed elimination resulted in significant infant exposures potentially persisting during breast-feeding," the research team reported. "Both regimens were well-tolerated. A total of 10 SAEs [serious adverse events] were reported in 5 mothers and 3 infants, with no significant differences between arms [the two medications]."

The DolPHIN-2 study will look at the impact of "significant infant DTG exposures related to intrauterine transfer, continued breastfeeding and delayed elimination."



REBECCA ZASH, MD

The women, all in Uganda and South Africa, took dolutegravir or efavirenz along with two HIV NRTI medications. Dolutegravir is found in Tivicay, Juluca, and Triumeq. Efavirenz is found in Sustiva and Atripla.

Birth defects have recently been associated with dolutegravir. See the following item, as well as the *Briefly* section of the POSITIVELY AWARE July + August issue.

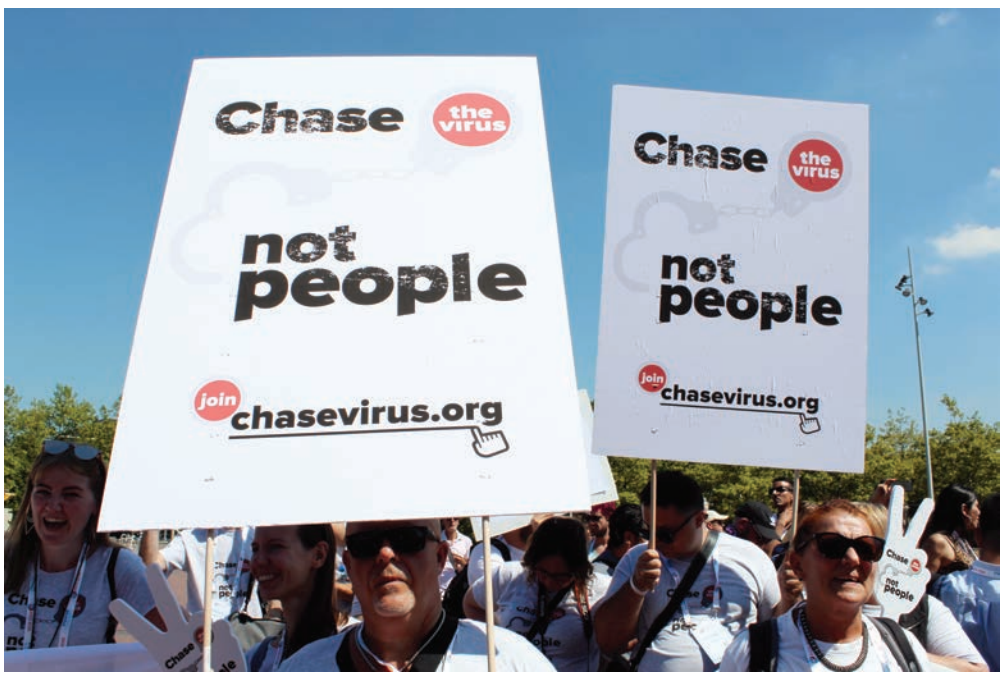
▶ Dolutegravir and birth defects

FOLLOWING RECENT WARNINGS of the potential for neural tube defects to newborns of women taking dolutegravir at the time of conception, Rebecca Zash, MD, of the Beth Israel Deaconess Medical Center, provided an update.

In the earlier report, preliminary data showed that four out of 426 infants born to women who were taking dolutegravir at the time of conception experienced neural tube defects. This was less than one percent (0.94%), but higher than the 0.12% found among women taking a non-dolutegravir regimen at the time of conception (14 infants out of 11,300).

However, not one infant out of 2,812 whose mother started dolutegravir during pregnancy had a neural tube defect.

Researchers are looking to further surveillance to



Central Asian and Eastern European activists at AIDS 2018 promoted the campaign "Chase the virus, not people!" Their logo consists of a pair of handcuffs with one locked on the virus, but the one representing people left wide open. They called it "a symbol of limited freedom and actions." Go to chasethevirus.org.

ACTIVISTS: JEFF BERRY · ZASH: ©ROB HUIBERS-IAS

confirm any link between dolutegravir and this potential side effect, which consists of birth defects of the brain, spine, or spinal cord.

▶ The Amsterdam Affirmation: People, Politics, Power

FOR EVERY international AIDS conference, the organizer, the International AIDS Society (IAS), and its partners create a sign-on declaration. The declarations focus on needed changes to end the pandemic. This year's declaration was "The Amsterdam Affirmation: People, Politics, Power."

"Much has changed since the global HIV community convened at the previous International AIDS Conference in Durban in 2016. Advances in science have been significant, including widespread acceptance that HIV is untransmittable with an undetectable viral load, increased PrEP rollout, innovative treatment delivery methods, and promising developments in cure and vaccine research. But while there have been success stories, prevention efforts continue to lag and new HIV infections are still on the rise among key populations and young women and girls. These groups continue to experience high levels of structural violence and stigma. Coupled with a rising tide of populism, questionable political commitment and leadership, and declining financial resources, the HIV response is operating in a fragile environment. People, politics, and power lie at the heart of the AIDS epidemic. How these intersect will continue to be critically important in achieving the agreed global targets and universal health coverage."

READ THE SUGGESTIONS of this declaration and sign on at aids2018.org.

Expert panel: HIV criminalization is discriminatory and at odds with science

BEKKER: ©MARTEN VAN DIJL-IAS

AN INTERNATIONAL TEAM of 20 prominent medical providers and researchers struck a blow against HIV criminalization with a detailed expert consensus statement in time for AIDS 2018.

"Simply put, HIV criminalization laws are ineffective, unwarranted, and discriminatory," said co-author Linda-Gail Bekker, MD, of the Desmond Tutu HIV Foundation in Cape Town, and out-going president of the International AIDS Society (IAS), which organizes the international AIDS conferences, in a press release. "In many cases, these misconceived laws exacerbate the spread of HIV by driving people living with and at risk of infection into hiding and away from treatment services."

The statement stresses that:

There is no possibility of HIV transmission via saliva, including kissing, biting, or spitting.

The risk of transmission from a single act of unprotected sex is very low, and there is no possibility of HIV transmission during vaginal or anal sex when the partner living with HIV has undetectable viral load.

It is not possible to prove HIV transmission from one person to another, even with the most advanced scientific tools.

The consensus statement was published in the scientific *Journal of the International AIDS Society* (JIAS). In its detailed report, it notes that such laws also seem to be punitive measures against certain groups of people.

Overall, the detailed report notes that criminalization laws ignore the science while perpetuating ignorance, stigma, and irrational fear.

"It is the hope of the Editors that this document will better inform readers about the reasons why criminalization will not help reduce transmission, but only fuel the epidemic," wrote JIAS Editor-in-Chief Kenneth Mayer, MD, of Fenway Health in Boston, along with colleagues, in an accompanying editorial. "We therefore hope that governmental authorities will view this Expert Consensus Statement as a resource to better understand the actual rather than the perceived risks posed by exposures to individuals living with HIV, and to create societies that encourage engagement and not fear."

The report concluded that, "The application of up-to-date scientific evidence in criminal cases has the potential to limit unjust prosecutions and convictions. The authors recommend that caution be exercised when considering prosecution, and encourage governments and those working in legal and judicial systems to pay close attention to the significant advances in HIV science that have occurred over the last three decades to ensure current scientific knowledge informs application of the law in cases related to HIV."

READ THE FULL CONSENSUS STATEMENT at onlinelibrary.wiley.com/doi/full/10.1002/jia2.25161. —EV

STILL KICKING

Mosaic HIV vaccine shows immune responses one year after final vaccination

BY **WARREN TONG** @warrentong

HIV vaccine regimens continued to show immune responses in monkeys and humans up to a year after the last vaccination, according to results presented at AIDS 2018 in Amsterdam. The vaccine in this study is called a mosaic-based vaccine because it contains various components that are designed to bring about immune responses against many different HIV strains.

The results, which were presented by Frank L. Tomaka, M.D., of Janssen Pharmaceuticals, highlighted 96-week data from the APPROACH study, which builds on the promising 48-week results reported last year at IAS 2017 and recently published in *The Lancet*. Notably, the vaccine regimens were safe and well tolerated, with no vaccine-related serious adverse events.

"The APPROACH data presented in Amsterdam provides additional data with longer-term follow-up of this vaccine regimen. This mosaic vaccine proved safe and prompted a broad and durable immune response to HIV in this trial and further supports the decision made last year to advance the candidate into a larger efficacy trial," Mitchell Warren, executive director of AVAC (formerly the AIDS Vaccine Advocacy Coalition), told POSITIVELY AWARE.

Who was studied?

THE STUDY FOLLOWED about 400 healthy individuals who were randomized to receive one of eight different regimens (seven variations of vaccines or a placebo). Among the participants, 54% were male and 46% were female; while 56% were black, 26% were white, and 16% Asian. In terms of geographic demographics, 38% were in the U.S., 33% were in Eastern Africa, 14% in South Africa, and 15% were in Thailand.

What was the vaccine regimen?

THIS STUDY USED a prime-boost approach, which consists of a multi-part vaccination schedule. The initial vaccination known as the prime is followed by a second vaccination known as the boost. In the APPROACH study, there were two primes and two boosts.

The study participants were split into eight groups. All groups received the same prime vaccinations using adenovirus 26 (Ad26), which is based on a flu virus, as a vector to deliver the vaccine. After the primes, participants received different boost regimens. The boost regimens contained Ad26 again; modified vaccinia Ankara (MVA), which is based on a pox virus; no viral vector; or a placebo. The boosts also may have included a low or high dose of gp140 protein, which is a structure typically found on HIV's envelope.

The eight groups received one of the following vaccine regimens:

- Ad26 prime + Ad26 and high-dose gp140 boost
- Ad26 prime + Ad26 and low-dose gp140 boost
- Ad26 prime + Ad26 boost
- Ad26 prime + MVA and high-dose gp140 boost
- Ad26 prime + MVA and low-dose gp140 boost
- Ad26 prime + MVA boost
- Ad26 prime + high-dose gp140 boost
- Placebo

How did the vaccine perform?

TO BE CLEAR, the study did not test whether the vaccines would protect against HIV in humans. This early phase only tested for safety and immune responses.

That being said, all of the vaccine regimens showed similar durability in immune responses. For the leading regimen (Ad26 prime + Ad26 and high-dose gp140 boost), 100% developed an antibody response, which was maintained for the whole study period, including a year after vaccination.

The researchers also tested to see if participants would develop immune responses to a panel of nine gp140 antigens. For the leading regimen, 100% responded to the antigens at week 52 and 80% responded to the antigens at week 96.

The vaccine regimens continued to be safe and well tolerated for the entire study period.

Parallel monkey study

THE RESEARCHERS also conducted a parallel study in monkeys known as NHP 13-19. This study used the same vaccine regimens and followed a similar dosing schedule as the human study. The leading vaccine regimen provided a 94% risk reduction per exposure of HIV, and complete protection against SHIV (an engineered simian-HIV hybrid virus) in 67% of the monkeys after all six weekly challenges.

Although animal results don't often translate into humans, Dr. Tomaka noted that the immune responses compared favorably between the two species. "In general, the human responses are high overall with improved persistence. One of the most encouraging observations is that after the third vaccination, the responses seen in the humans are higher than the responses in the monkeys at the time that they were protected from the SHIV challenges," Dr. Tomaka said.

Although the results are promising, actual effectiveness or protection against HIV remains to be seen.

Next steps

TO DATE, there has been only one HIV vaccine candidate that has shown efficacy in humans. That was the RV144 study, also known as the Thai trial, which showed a moderate 31% efficacy back in 2009. RV144 also used a prime-boost strategy, but used a different vaccine regimen.

Because of the promising results from the APPROACH study, researchers started a phase-2b study, known as Imbokodo, in November 2017. The Imbokodo study will run for five years and enroll up to 2,600 young women in South Africa. Researchers expect first results in 2021.

What level of effectiveness would make the vaccine successful?

"THE IMBOKODO STUDY is looking at safety and efficacy, so there is no single efficacy number or result that would mean success, and this trial is just one of a couple that would likely be required for actual licensure of the vaccine," said Warren.

"That said, it is hoped that we would see efficacy over 50% and ideally durable for more than a year or two as the basis for a vaccine that we could imagine delivering as part of a comprehensive HIV prevention program," he added.

WARREN TONG is a freelance health and science journalist, with an extensive background writing about HIV and hepatitis C.


TO EVERYONE WHO HELPED GET US HERE:
THANK YOU!
15th ANNIVERSARY
THE RIDE FOR AIDS CHICAGO
PRODUCED BY
TPAN
PUBLISHER OF POSITIVELY AWARE
GILEAD
Hill-Rom
mb financial bank
AHF
AIDS HEALTHCARE FOUNDATION
Proud To Run Chicago
AAC
Athletic Alliance of Chicago
circuit mom
KOZY's
Rapha
CHICAGO
SOULCYCLE
velofix
Save Time. Ride More
velosmith
bicycle studio
Lifeway
VISION QUEST
COACHING
ROSCOE VILLAGE BIKES
ZONE perfect.
rideforaids.org