POSITIVELY AWARE

HIV TREATMENT, PREVENTION AND HEALTH FROM TPAN
SEP+OCT 2022

AIDS 2022
MONTREAL CONFERENCE UPDATE

'ONWARD AND UPWARD'

After nearly 18 years as PA's editor-in-chief, **JEFF BERRY** is moving on
THE EXIT INTERVIEW

TWO-PIECE STRATEGY
Using prisons to end HIV

'SHE PLANTED A SEED'
Carla Davis couldn't see the brightness of her future

NOT A FELON, BUT A HUMAN BEING
Words to set people free

POSITIVELY AWARE

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

BE GREEN.
SHARE OR RECYCLE
THIS MAGAZINE.

A Day with HIV is 24 hours in the lives of people affected by HIV —and that's all of us.

What will your picture be?

A DAY WITH HIV
Get in the picture on
9/22/2022

The idea behind **A Day with HIV** is to portray a single 24-hour period in the lives of people affected by HIV. This **Thursday, September 22, 2022**, wherever in the world you are, take a snapshot of whatever you're doing that day; post it to your social media with a caption that includes the time and location of your photo, and what inspired you to take it. Add the hashtag **#adaywithhiv.** Select photos will be featured in the NOV+DEC issue of POSITIVELY AWARE—some will appear on the cover.

#adaywithhiv

SEP+OCT 2022

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EVERY ISSUE

THIS ISSUE

IAS 2022
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BEHIND THE COVER

Time for one last shot

ON LOCATION: PHOTOGRAPHING THE COVER IN TPAN'S RECEPTION AREA.

BACK ISSUE: OCTOBER 1993 COVER AND ARTICLE

THE FIRST TIME Jeff Berry stepped in front of a camera for the cover of POSITIVELY AWARE was for the magazine's October 1993 issue. He was the distribution coordinator back then, and reluctantly agreed to step in.

With Jeff departing after more than 18 years as editor-in-chief, it seemed appropriate to give him his own cover one more time.

Looking back while looking ahead led to the idea behind this cover, with Jeff holding up that 1993 issue while standing next to a rack of more recent issues of the magazine. It illustrates not only his editorial career, but the role that POSITIVELY AWARE has played in his personal life, living more than 30 years with HIV.

—RICK GUASCO

PHOTOGRAPHY BY JOHN GRESS.
STYLING BY WILLIAM MARTINEZ.
POSITIVELY AWARE OCTOBER 1993 COVER PHOTOGRAPHER: GENYPHYR NOVAK. OCTOBER 1993 COVER MODELS: JEFF BERRY AND GINA.

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EDITOR'S NOTE

JEFF BERRY
@PAeditor

One more thing...

To every thing (turn, turn, turn)
There is a season (turn, turn, turn)
And a time to every purpose, under heaven
—**PETE SEEGER**, SONGWRITER

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.
—**MAYA ANGELOU**, AUTHOR

Give a girl the right shoes, and she can conquer the world.
—**BETTE MIDLER**, SINGER, PERFORMER, *THE DIVINE MISS M*

When I first stepped up as interim editor of POSITIVELY AWARE in 2004, I had three issues of the magazine that I had to work on right away: the current issue that hadn't quite been completed by my predecessor Charles Clifton, who had died suddenly and unexpectedly; the 2005 HIV Drug Guide, a behemoth of an issue every year; and a special issue on pharmacokinetics and pharmacodynamics, a highly technical topic which I knew little to nothing about. It was kind of a sink or swim moment, a baptism by fire if you will, but with the help and support of my friends, colleagues, and co-workers, I was able to meet the challenge head on, and persevere—and the rest, as they say, is history.

Flash forward 18 years later, and the time has come for me to move on from TPAN and POSITIVELY AWARE for a new opportunity. I have been with this amazing organization for 30 years, and during that time have been incredibly blessed to be able to share my journey with you, and give a voice to the voiceless, a rare opportunity that I don't take lightly.

My very first editor's note was actually never printed, and discarded long ago. It was basically an 800-word tirade against people and organizations who, I wrote at the time, held their glitzy self-congratulatory AIDS fundraisers, wore their red AIDS ribbons once a year, and then moved on with their lives, while the rest of us with HIV had to continue to live with it every day. When I showed it to my sister Wendy and asked for her feedback, I'll never forget it. "What are you trying to accomplish?" she asked. "What is your end goal?"

It was an angry piece, but I realized my anger was misdirected, and I began to understand how important it was that I set the right tone from the beginning, and bring the reader along, not just piss them off for the sake of pissing them off. Since then, I've always written my editor's notes from the heart, from my own perspective, sharing my own journey, in the hopes that it might help someone else, that it might resonate somehow. A lot of it was really a leap of faith, faith in myself, faith in others, faith that my writing and ramblings somehow made sense to someone other than just me. I don't want to speak for others, because I can't pretend to know what their experiences are, only my own. It was, and continues to be, a valuable lesson for me.

I will miss this incredible platform I've been entrusted with to speak my own truth, but it's time for a new, fresh perspective for POSITIVELY AWARE, and I'm so grateful to be leaving it in such good hands with interim editor Rick Guasco and associate editor Enid Vázquez.

Everything changes, and nothing stays the same, at least while we're here on this planet—you've probably heard the saying, "we are spiritual beings having a human experience." So, this is not goodbye, maybe just call it a change of venue. I'll still continue to advocate for people living with HIV, with a focus on those with HIV who are aging and long-term survivors. Still connecting, still fighting, still making sure there is a place for those who are not at the table, even if that means I have to give up my seat at some point. I'll be glad to make way for the next generation of fighters and dreamers. We need you.

We are spiritual beings having a human experience. **So, this is not goodbye, maybe just call it a change of venue.**

Until then, be kind to each other, know that you and your life have meaning, and that your story is unique—it belongs to you, and you alone. Never walk in shame, but instead hold your head up high, and use your gift as a way to help others who, while you may not realize it, may be going through the same thing. Sometimes when we take that leap of faith to share our deepest and darkest secrets, it allows someone else to break free from the chains that bind. You may realize that what you were holding in, was holding you back. Learn to forgive others, and most of all, forgive yourself.

Oh, and one more thing.

Please take care of yourself, and each other.

Briefly

ENID VÁZQUEZ @enidvazquezpa

Twice-yearly lenacapavir for multidrug-resistant HIV gets European approval

A once-every-six-months formulation of Gilead Sciences' lenacapavir, the first in its class HIV capsid inhibitor, has been approved by the European Commission, in combination with other antiretroviral medications, for adults with multidrug-resistant HIV who have no other effective treatment options available.

The new regimen requires a lead-in phase with oral lenacapavir tablets, which have also received European approval, before starting the twice-yearly under-the-skin injections. This is not a standalone treatment; twice-yearly lenacapavir still needs to be taken with other HIV medications.

"Lenacapavir provides an innovative long-acting HIV therapy option with the potential to transform the clinical landscape," said Jean-Michel Molina, MD, Université Paris Cité, professor of infectious diseases and head of the Infectious Diseases Department at the Saint Louis and Lariboi0sière Hospitals.

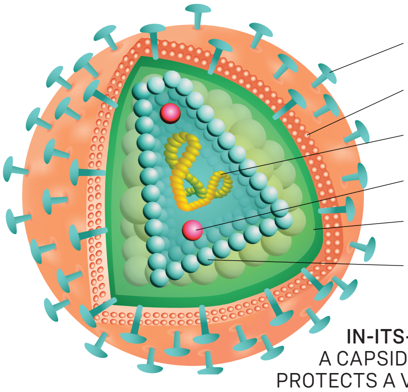
In the phase 2/3 CAPELLA study, lenacapavir in combination with an optimized background regimen helped 83% of heavily pretreated patients with multidrug-resistant HIV achieve undetectable viral load after one year of treatment.

Lenacapavir has no known cross-resistance to other existing HIV drug classes, and has a high barrier to viral drug resistance.

Gilead will market six-month lenacapavir in Europe under the brand name Sunlenca. The commission's marketing authorization applies to all 27 member states of the European Union, as well as Norway, Iceland, and Liechtenstein.

After resolving a production issue with glass vials, Gilead resubmitted lenacapvir's application for FDA approval. The FDA has set December 27, 2022 as the target date for its decision. A Phase 3 PURPOSE trial is evaluating lenacapavir as a PrEP drug for preventing HIV.

—**RICK GUASCO**



LENACAPAVIR IS A FIRST-IN-ITS-CLASS CAPSID INHIBITOR. A CAPSID IS A PROTEIN SHELL THAT PROTECTS A VIRUS' GENETIC MATERIAL.

Trogarzo wants a faster push

Theratechnologies is seeking FDA approval for a second option for administering Trogarzo. The long-acting entry inhibitor and CD4 post-attachment inhibitor currently has a loading dose of 2,000 mg infused over 30 minutes, with subsequent maintenance doses of 800 mg infused over 15 minutes, The new option would allow for the maintenance dose to be administered as an intravenous push over 30 seconds.

The proposed method would still need to be administered by a qualified health care professional. Administered every two weeks, Trogarzo is for people living with HIV who are heavily-treatment experienced. It must be taken with other HIV medications as part of the regimen.

HIV testing nearly halved during COVID's first year

The Centers for Disease Control and Prevention (CDC) reported a nearly 50% drop in HIV testing in 2020, the first year of COVID-19, for some populations most affected by the virus. Among tests provided by the CDC in non-health care settings that report race and/or ethnicity data and transmission status, screenings were down from 2019 to 2020 by

- 49% among gay and bisexual men
- 47% among transgender people
- 46% among Hispanic and Latinx people
- 44% among Black people

"HIV testing is the bridge to highly effective treatment and prevention," the CDC reported in announcing its findings ahead of National HIV Testing Day, June 27. "Delayed diagnoses can lead to negative health consequences and increased HIV transmission." The agency pointed to its recommendation that everyone between the ages of 13 and 64 get tested at least once and that some people get tested at least annually. To find free and confidential tests, call 1-800-CDC-INFO (232-4636). Rapid tests are also available from pharmacies.

READ THE REPORT at bit.ly/HIV-testing-drops-over-covid.

Monkeypox, gay men, and—once again—stigma

With most cases of monkeypox in Europe and the United States occurring among gay and bisexual men, stigma has once again reared its ugly head.

In an editorial, *The Lancet Infectious Diseases* journal noted, "This raises the question, how to provide health information to a population at risk (here MSM [men who have sex with men]) without stigmatizing them?"

"With outbreaks, such as the current monkeypox one, the most important thing that needs to happen is that those infected seek medical care. Stigma—i.e., blaming and shaming an individual for their infection—can prevent this and, in turn, prevent contact tracing and other containment measures," the editorial noted. "Some might hope that stigma serves as a corrective of (real or

TOP OF THE NEWS

➤ Students living with HIV awarded scholarships ➤ Monkeypox, gay men, and—once again—stigma ➤ U=U gets official backing of U.S. and Canada ➤ Lawsuit charges HIV discrimination at correctional facility ➤ On-demand PrEP? *Oui!* ➤ PrEP use data comes to life in new graphics ➤ First Black queer man named to lead South Puget Sound HIV agency

perceived) behavior. However, we know from the ongoing HIV pandemic that shame does not prevent transmission and only leads to individuals suffering and dying in isolation."

In considering many aspects of information provided, there is also the danger that individuals may become complacent if they feel that the people or groups affected do not include them.

"The messaging is therefore incredibly important. Any message must provide the facts—that certain groups are more at risk and might be more likely to require medical attention—without apportioning blame," according to the editorial. "It also needs to be accompanied by admissions of uncertainty—e.g., that a certain group is at risk now, but that the virus does not discriminate, and anyone could become infected. This both prevents a false sense of security in the rest of the public and also reduces feelings of frustration or confusion when information is updated."

The editorial concludes that, "While it may be comforting to believe that a disease can only affect others, such thinking will not control an outbreak and stigmatizing may well extend it."

READ the editorial, posted July 7 at bit.ly/Lancet-editorial-monkeypox-stigma.

On-demand PrEP? *Oui!*

Once again (and again), the ANRS PREVENIR Study Group in France reports that on-demand PrEP is just as effective as daily PrEP for preventing HIV among gay and bisexual men: "On-demand PrEP >>

COURTESY OF PREVENTION ACCESS CAMPAIGN

FROM LEFT: DEONDRE MOORE, B. KAYE HAYES, HAROLD PHILLIPS, DR. THERESA TAM, AND DR. HOWARD NJOO FOLLOWING THE ANNOUNCEMENT IN MONTREAL.

U=U gets official backing of U.S. and Canada

In a joint appearance, health officials from the U.S. and Canada announced official support of U=U, Undetectable Equals Untransmittable, at the U=U Global Summit held just before the AIDS 2022 conference in Montreal.

U=U is the science-based principle that a person living with HIV who is on antiretroviral treatment and has an undetectable viral load (less than 200 copies/mL) cannot transmit HIV through sex. The Prevention Access Campaign (PAC) launched the U=U campaign in 2016 to build scientific consensus behind this often-unknown fact.

Harold Phillips, director of the White House Office of National AIDS Policy, made the announcement, accompanied by Kaye Hayes, deputy assistant secretary for Infectious Disease and director of the Office of Infectious Disease and HIV/AIDS Policy at the U.S. Department of Health and Human Services, and Dr. Demetre Daskalakis, director of the Division of HIV Prevention at the Centers for Disease Control and Prevention (CDC).

Calling it a "key message that's critical to ending HIV," Phillips shared how U=U counteracted his own internalized stigma. He pledged that the federal government will, "seek opportunities to work with our government and stakeholders to incorporate U=U messaging in federal training, grants, and educational programs."

Canada's Chief Public Health Officer, Dr. Theresa Tam, urged all nations to support and leverage U=U to accelerate efforts to end the HIV epidemic.

"U=U is a transformative message for people living with, and affected by, HIV," Tam said. "It is also an important tool to help us reach our shared targets for diagnosis, treatment and prevention. The evidence behind U=U holds tremendous power to reduce the stigma that can prevent people from getting tested and freely accessing the treatment and support they need."

Deondre Moore, PAC's director of U.S. Partnerships and Community Engagement, stressed that addressing health disparities in communities of color is essential to the success of U=U.

"We believe this national and global support is a step in changing that," Moore said. "We can't fully celebrate U=U until it is a reality for all, not just the privileged."

GO TO preventionaccess.org for details.

>> **therefore represents a valid alternative to daily PrEP for MSM** [men who have sex with men], providing greater choice for HIV prevention."

During 2017–2019, more than 3,000 participants at 26 sites in Paris were prescribed either a daily pill of Truvada for PrEP or an on-demand schedule of "2-1-1" as used in the IPERGAY study (two pills 2–24 hours before sex, one pill 24 hours after the first dose, and one pill 24 hours after the second dose). About half of the participants elected to use on-demand Truvada for PrEP.

The HIV treatment and prevention guidelines from IAS-USA (the International AIDS Society-USA) recommends on-demand PrEP for MSM.

ANRS is an agency of France's version of the National Institutes of Health, responsible for funding and coordinating the country's HIV research. The ANRS study was published in the August 2022 issue of *The Lancet HIV*.

Students living with HIV awarded scholarships

The HIV League in July announced the award of college scholarships for a cohort of 19 students who are living with HIV. The league is a nonprofit organization dedicated to scholarship, wellness, and education for people living with the virus. Many of them chose to remain anonymous. Among the awardees open about their status are Sabian Castalia, who's majoring in film production at Brooklyn College, and Martez Smith, a doctoral candidate in nursing and health science at the University of Rochester School of Nursing.

Castalia defines herself as "a queer, Latinx filmmaker and media archivist who strives to use entertainment as a tool to educate and empower audiences." She began studying film and art as activism in California. She says that her current work "aims to destigmatize sex education and the pursuit of sexual health care by amplifying themes of humor, empathy, and joy."

Martez holds a bachelor's of social work from The Ohio State University and a master's of social work from Long Island University Brooklyn. He is interested in conducting research that "addresses racial, sexual, and gender minority health disparities through community-driven, asset-based interventions." He also works nationally with activists organizing for social justice with the Keeping Ballroom Community Alive Network (KBCAN), which he co-founded in 2015, and has worked on health and social welfare initiatives. His dissertation explored motivations for sexual health among Black and Latino men who have sex with men in New York City's house ball community. Martez is a third-time HIV League Scholar. He is also a fellow in the Brown [University] Community and Clinical Research Training (CCRT) Program. CCRT aims to train the next generation of researchers to end the HIV epidemic and to conduct research related to reducing racial disparities in HIV outcomes.

According to the league, this is **the only national scholarship program for students with HIV**. But, it noted, the scholarships represent more than that.

"Because of the many intersectionalities individuals in the HIV community hold, the HIV League Scholarship also works to bring higher educational equity among LGBTQIA2S+ students, students who identify as a woman, and BIPOC (Black, Indigenous, People of Color) students as well," the organization reported in its announcement of the awards. This year, the league also set aside monies specifically for a new Trans BIPOC scholarship, for trans-identifying students.

Full-time students are scheduled to receive either $3,500 over one year or $7,000 over two years. Part-time students will receive $1,500 over one year.

READ more about inspirational scholars at hivleague.org.

Bilingual PrEP campaign launches in Chicago

A community-based partnership of HIV service and prevention providers in Chicago has launched *PrEPárate*, a bilingual campaign in Spanish and English promoting HIV prevention via medicine. **One important message: PrEP is free or low-cost for everyone**.

The campaign went live in July on the buses and trains of the Chicago Transit Authority (CTA) and on social media (@cookcountyresearch on Instagram). Campaign ambassadors talk about HIV prevention medication in videos posted to preparate.info. ¡*Viva!*

Prepárate is Spanish for "prepare yourself." It's commonly used to say, "Get ready." It's the same word used for male and female genders. (In Spanish, some words have a male and a female version.)

Anyone needing help accessing PrEP in Illinois can call the PrEP Hub at (844) 482-4040.

The community partnership was brought together by Cook County Health, Northwestern University, and the University of Chicago. *Muy bien*, titans. Very good.

Campaña bilingüe para PrEP en Chicago

La campaña bilingüe en inglés y español *PrEPárate* promueve la PrEP para prevenir el VIH entre las comunidades latinas/x/o en la ciudad de Chicago y todo el estado de Illinois. La PrEP (profilaxis prexposición) son medicamentos que se toman para prevenir contraer el VIH a través de las relaciones sexuales o el consumo de drogas inyectables. **La campaña declara que la PrEP es para ti y para mí.** **VÉA VIDEOS** sobre la PrEP en la página preparate.info. Para más información en español, **VISITE LA PÁGINA** preparate.info/español/sobre-la-prep. En Illinois, llame al PrEP Hub para acceder a la PrEP: (844) 482-4040.

PrEP CAMPAIGN TAKES TO CHICAGO PUBLIC TRANSIT

ENID VÁZQUEZ

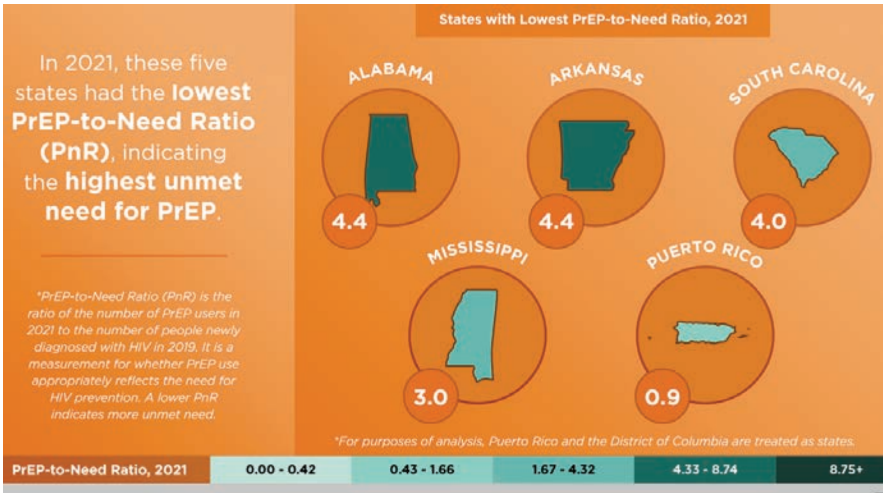
PrEP use data comes to life in new graphics

AIDSVu has released a new set of infographics featuring the first-ever publicly available state-level data and regional maps on PrEP use by race and ethnicity, from 2012 to 2021. While use of PrEP has increased an average of 56% each year since its approval in 2012, **the graphics depict major inequities in PrEP use among people who are Black and Hispanic, and in the southeastern U.S.**

The southeast accounted for 52% of new HIV diagnoses in 2020, yet represented just 39% of PrEP users in the U.S. in 2021. The region also has the states with the highest unmet need for PrEP—Alabama, Arkansas, South Carolina, and Mississippi. (Although Puerto Rico falls under this category of greatest unmet need, it is not a state; it is a U.S. territory.)

“It is important that data do not live in a vacuum and that the insights we glean from research are translated into policy and action,” said Patrick Sullivan, DVM, PhD, professor of epidemiology at Emory University’s Rollins School of Public Health and principal scientist for AIDSVu. “Visualizing PrEP use data on AIDSVu draws attention to underserved people and geographic regions and helps prevention programs better allocate resources to ensure PrEP reaches the people and communities with the greatest unmet need for PrEP.” Dr. Sullivan presented the report on PrEP inequity at this year’s International AIDS Conference (see page 31).

AIDSVu provides interactive maps that visualize the impact of HIV. The site also offers resources to find local services. **GO TO** aidsvu.org. —**RICK GUASCO**



In 2021, these five states had the **lowest PrEP-to-Need Ratio (PnR)**, indicating the **highest unmet need for PrEP.**

**PrEP-to-Need Ratio (PnR) is the ratio of the number of PrEP users in 2021 to the number of people newly diagnosed with HIV in 2019. It is a measurement for whether PrEP use appropriately reflects the need for HIV prevention. A lower PnR indicates more unmet need.*

**For purposes of analysis, Puerto Rico and the District of Columbia are treated as states.*

AIDSVU

Lawsuit charges HIV discrimination at correctional facility

The following story is reprinted with permission from the *Good Counsel* newsletter of the AIDS Law Project of Pennsylvania, in its Spring 2022 issue. **READ** the newsletter at bit.ly/AIDS-law-project-fighting-discrimination.

The young man from central Pennsylvania was being held at the George Hill Correctional Facility in Delaware County on a probation violation. He wanted to work in the prison kitchen, but was denied because he is living with HIV.

“John” filed grievances with the privately managed prison, alleging that the staff had discriminated against him because of HIV and had told other inmates about his status. The prison responded that it was simply following policy. He escalated his complaints through the prison’s grievance system all the way to the warden, but at every level his concerns were dismissed.

In the spring of 2020, John contacted the AIDS Law Project of Pennsylvania. Throughout his incarceration, John sent us the denials he received from the facility. He was released in July 2020.

This April, a lawsuit was filed on John’s behalf under the Americans with Disabilities Act in the United States District Court for the Eastern District of Pennsylvania by the AIDS Law Project, Lambda Legal, and Scott Schoettes against Delaware County, GEO Group (the organization that runs the prison), and several individuals. [Editor’s note: Schoettes writes the *Poz Advocate* column for POSITIVELY AWARE.]

The complaint alleges violations of multiple laws, including the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and Pennsylvania’s Confidentiality of HIV-Related Information Act.

It’s not the first time that the AIDS Law Project has filed a lawsuit on behalf of a person living with HIV who was denied a job in food services:

As reported in the Fall 2011 issue of *Good Counsel*, we settled a lawsuit on behalf of a single mother of four living with HIV who was fired from her job at a snack-food factory in Lancaster after her supervisors learned of her status. (bit.ly/Good-Counsel-Fall-2011)

The Spring 2017 issue reported that we reached a settlement on behalf of a chef living with HIV after he and his fiancé were both fired from their jobs at a small-town country club because of HIV. The chef’s fiancé didn’t have HIV, but was fired due to fear of HIV. (bit.ly/Good-Counsel-Spring-2017)

The law on HIV and food handlers is clear. Since 1991, the Centers for Disease Control and Prevention (CDC) has been required to annually publish a list of infectious and communicable diseases that prohibit an individual from working in food services. HIV has never been on the list.

“We believe that this sort of discrimination and carelessness with private information happens all the time in prisons, and largely goes unaddressed,” said senior staff attorney Adrian M. Lowe. “In this case, because of our client’s careful documentation and dogged pursuit of resolution, we had a pile of evidence backing up his allegations.”

The lawsuit demands that the prison develop an anti-discrimination policy and conduct training for all staff regarding HIV, transmission, and universal precautions. The lawsuit also seeks compensatory damages, costs, and attorney fees.

TWO-PIECE STRATEGY

PYTYCZECH-ISTOCK

To end the HIV epidemic, implement proven HIV prevention strategies in the criminal justice system

BY **DANIEL TEIXEIRA DA SILVA, MD, MSHP**
AND **CHETHAN BACHIREDDY, MD, MSHP**

Criminal justice-involved populations are disproportionately affected by HIV. Each year in the U.S., 150,000 people living with HIV leave a correctional facility and likely don't receive HIV medical services and treatment. Marginalized populations are at increased risk of both HIV acquisition and incarceration, and this dual risk is amplified among communities of color.

The 2022–2025 HIV National Strategic Plan was released in December 2021 by the White House Office of National AIDS Policy, which had been disbanded by the previous administration. The updated Strategic Plan recognizes structural racism as a driver of HIV outcomes, emphasizes the role of harm reduction services in the national response to HIV, and includes objectives to increase the capacity of correctional settings to diagnose and treat HIV. However, the plan overlooks the role of HIV prevention strategies within correctional settings. Two such evidence-based strategies (i.e., the most effective based on research)—medication for opioid use disorder (MOUD) and HIV pre-exposure prophylaxis (PrEP)—are the focus of this article.

Prevention after being detained

Ending the HIV epidemic will require a comprehensive plan to prevent HIV among people most impacted by the criminal justice system. Besides the HIV National Strategic Plan—which serves as a roadmap for the Department of Health and Human Services' cross-agency initiative to reduce new HIV infections by 90 percent by 2030—there have been some efforts to understand and address the HIV epidemic in the criminal justice system. In 2009, the Centers for Disease Control and Prevention (CDC) released HIV testing and reentry guidance[1] for correctional settings. Two national multisite trials provided evidence to support HIV testing in correctional settings and linkage to community HIV care services post-release.

The EnhanceLink[2] Project was a five-year (2007–2012) special initiative funded by the Human Resources and Services Administration (HRSA) to evaluate approaches to link people living with HIV (PLWH) released from incarceration to community HIV care. EnhanceLink included 10 jails, and each developed their own approach that included jail-based HIV testing and case management for pre-release planning and post-release continuity of care. Evaluation of the EnhanceLink initiative found that jail HIV testing and reentry services were feasible and cost-effective approaches to reduce HIV transmission.

The HIV Services and Treatment Implementation in Corrections trial,[3] funded by the National Institute on Drug Abuse, evaluated a process improvement intervention to improve HIV services in 14 jails and prisons. Again, the trial provided evidence that HIV testing, treatment, linkage, and prevention services are feasible in correctional settings. The process improvement intervention was only found to be effective in improving prevention services, but not other services, which the authors attributed to staff dissatisfaction of having increased duties without increased support or compensation.

In 2020, HRSA's Ryan White HIV/AIDS Program[4] convened an expert panel to address the needs of PLWH in prisons and jails, highlighting the importance of access to medication during incarceration and linkages to community providers at release. Despite these efforts, in a national survey,[5] only 14 percent of state prisons and 30 percent of jails met CDC best practices for HIV testing, and only 19 percent of state prisons and 17 percent of jails met CDC best practices for discharge planning.

Jails and prisons are the only settings in which courts have recognized a constitutionally protected right to health care in the U.S. Although the criminal justice system has historically failed to deliver adequate health care, incarceration may be a platform[6] to improve outcomes among populations most affected by the twin epidemics of incarceration and HIV. Implementing evidence-based HIV prevention strategies in correctional settings is key to preventing HIV transmission among marginalized communities.

Populations at risk for acquiring HIV are disproportionately affected by the criminal justice system

Transgender women, Black women, Black men who have sex with men,[7] and people who inject drugs are disproportionately impacted by the criminal justice system and identified as priority populations by the HIV National Strategic Plan. The contribution of incarceration to the HIV epidemic is most profound among low-income Black communities and is a stark example of how structural racism leads to worse health outcomes.

Although Black Americans are less likely to use drugs[8] compared to their White counterparts, Black Americans are five times more likely[9] to be incarcerated for a drug offense. Nearly one in five[10] transgender women experience incarceration in their lifetime, and Black transgender women are three

THE REPORT INCLUDES SEVERAL EXAMPLES of successful MOUD programs in the criminal justice system across county and state settings that could have informed the HIV National Strategic Plan.

times[11] more likely to be incarcerated compared to their White counterparts. While incarcerated, more than one-third[12] of Black transgender women report being sexually assaulted.

The HIV epidemic in the U.S. is concentrated among Black men who have sex with men, who have a lifetime risk of HIV diagnosis of one in two,[13] compared to one in 11 among their White counterparts. Racial disparities are also stark among transgender women, with an estimated HIV prevalence of 44.2 percent[14] among Black transgender women compared to 6.7 percent among their White counterparts. More than half[15] of Black men who have sex with men are likely to have experienced incarceration in their lifetime, and criminal justice involvement among Black men may also contribute to HIV acquisition among Black cisgender women[16] in the community setting. Incarceration disrupts social support networks and jeopardizes post-release employment and housing. A criminal record compounds the discrimination and lack of opportunity already experienced by racial, sexual, and gender minoritized populations.

The criminal justice system has been a cornerstone of structural racism[17] since the end of the Jim Crow era and has significantly contributed to racial inequity in HIV outcomes. The lifetime risk of HIV diagnosis[18] among Black men is one in 20 and among Black women is one in 48, compared to one in 132 for White men and one in 880 for White women. Strengthening HIV services in correctional settings will not only improve HIV outcomes among priority populations identified by the HIV National Strategic Plan but will also advance the overarching goal of reducing health inequity. To recognize racism as a serious public health threat, the updated HIV National Strategic Plan must demonstrate a commitment to people and communities who disproportionately experience incarceration.

Medication for opioid use disorder

More than one in six[19] male inmates, and one in four female inmates, regularly use opioids prior to incarceration, and the risk of fatal overdose increases up to 129-fold[20] among prisoners who have recently been released. The Bureau of Justice Statistics[21] estimates that approximately 60% of people who are incarcerated in the U.S. meet criteria for substance use dependence or abuse, yet less than1% receive MOUD while incarcerated.

Current evidence[22] supports providing MOUD in correctional settings; starting MOUD during incarceration[23] can significantly reduce the risk of overdose, reduce injection-related HIV risk behaviors, and increase community treatment engagement post-release.[24] Providing MOUD prior to release and incorporating MOUD into re-entry programs has been associated with HIV viral load suppression[25] after re-entry, improving the lives of PLWH who have been incarcerated and decreasing the risk of transmission among communities disproportionately impacted by incarceration.

Despite such evidence and the recommendations by federal agencies[31] within the Department of Health and Human Services and the National Academies of Science, Engineering, and Medicine,[32] the importance of MOUD in correctional settings is missing from the HIV National Strategic Plan. Recently the CDC[33] released a report describing an alarming increase in overdose deaths among Black adolescents and adults. By neglecting to support MOUD in correctional settings, the HIV National Strategic Plan reinforces inequity in HIV outcomes among Black communities who are more likely to experience incarceration and threatens to stymie efforts to end the HIV epidemic.

In its report "Use of Medication-Assisted Treatment for Opioid Use Disorder in Correctional Settings,"[40] the Substance Abuse and Mental Health Services Administration[41] details six areas to enhance delivery of MOUD in the criminal justice system: 1) overcoming stigma; 2) addressing threats to safety and security; 3) advancing staff knowledge and skills; 4) covering the cost of MOUD; 5) establishing MOUD providers in correctional institutions; and 6) building partnerships with community-based treatment. The report includes several examples[42] of successful MOUD programs in the criminal justice system across county and state settings that could have informed the HIV National Strategic Plan.

Pre-exposure prophylaxis

HIV transmission during incarceration[43] is more likely to occur among Black inmates and men who have sex with men, and it is also associated with prison tattooing. Despite the elevated risk of HIV transmission within jails and prisons, most inmates do not have access to methods to prevent HIV infection, such as clean needles, condoms, and, vitally, daily PrEP,[44] which prevents up to 99 percent of HIV transmission from sex and more than 70 percent of HIV transmission from intravenous drug use. In fact, PrEP has yet to be implemented[45] in any correctional setting. Barriers to implementing PrEP in correctional settings may include lack of knowledge among clinicians, HIV-related

Federal policy on MOUD in correctional settings

Since the Affordable Care Act was enacted there has been increasing momentum in federal legislation to strengthen access to medication for opioid use disorder (MOUD) in correctional settings. People who are incarcerated are subject to Medicaid and Medicare's inmate exclusion policy, which prohibits the use of federal funds to provide outpatient medical care in correctional settings. However, in 2016[26] the Centers for Medicaid and Medicare (CMS) published guidance for state Medicaid agencies to suspend, rather than terminate, Medicaid eligibility and benefits for people who are incarcerated, as well as provide screening and enrollment services during a period of incarceration. The 2018 SUPPORT Act[27] prohibited the termination of Medicaid eligibility for juveniles, and included provisions to convene stakeholders to develop best practices for providing MOUD in correctional settings. To facilitate the implementation of the SUPPORT Act, CMS published further guidance[28] that acknowledged the inmate exclusion policy as detrimental to continuity of care. Last year, there was bipartisan support for the Medicaid Reentry Act of 2021[29] that would authorize Medicaid to reimburse outpatient healthcare services in the last 30 days of incarceration and strengthen reentry services. The Act was folded into the larger Build Back Better Bill, which ultimately failed to pass Congress. This past February the Biden administration released a statement[30] to establish a Medicare special enrollment period of six months following release from incarceration. The current HIV National Strategic Plan fails to acknowledge the role of these federal policy initiatives in improving correctional HIV services.

stigma in correctional settings,[46] and inability of some facilities to run laboratory tests for HIV, kidney function, hepatitis B antibodies, and other indicators of disease.

Fortunately, best practices for corrections-based provision of PrEP are being developed.[47] Lauren Brinkley-Rubinstein and colleagues[48] detail a path toward implementing PrEP for people involved in the criminal justice system that includes providing training to criminal justice-based clinicians, developing standards and protocols specific to criminal justice settings, and identifying best practices within correctional facilities. In a study[49] evaluating PrEP knowledge among 417 inmates, only 12 percent knew about PrEP, but 25 percent were interested in initiating PrEP; thus, a clear starting point for implementing medical HIV prevention within the criminal justice system is HIV education.

HIV reentry services

Federal efforts to strengthen MOUD in correctional settings have motivated policy change to improve reentry services. The updated HIV National Strategic Plan, however, seems to be out of sync with these efforts, and misses an opportunity to elevate the importance of improving HIV reentry services on the national stage. Without HIV reentry services, gains made in correctional settings, such as achieving viral load suppression and increased linkage and retention in HIV care, can be lost upon release.[34] The consequences can be fatal. In the year following release from incarceration, PLWH have a seven-times greater risk of death[35] compared to the general population. Most of those deaths, attributed to HIV/AIDS, are preventable with antiretroviral therapies (ART). Unfortunately, a study[36] of 2,015 PLWH released from incarceration found that only 18% filled a prescription for ART within 30 days of release. Another study[37] of 1,350 PLWH released from incarceration found that 34% were linked to HIV care within 30 days of release. However, a recent systematic review[38] identified 16 controlled clinical trials aimed at improving post-incarceration ART adherence and engagement in HIV care. Promising approaches included intensive case management, peer navigation, financial incentives, and providing cell phones. Without engagement in care or receipt of antiretroviral therapies, PLWH released from incarceration are more likely to have detectable HIV viral loads that can lead to community HIV transmission. In a study[39] of nine U.S. cities, a 10-person increase in prison release rates within a given ZIP code increased the overall 5-year HIV diagnosis rate by four percent. The HIV National Strategic Plan recognizes barriers to care experienced by people released from correctional facilities, but does not acknowledge this evidence base for HIV reentry services and neglects to commit specific strategies to improving them.

If integrated into the criminal justice system, the benefits of PrEP may continue post-release. Recently released people who inject drugs[50] are more likely to acquire HIV. The communities that inmates return to post-release[51] experience higher rates of HIV incidence. Black Americans face further barriers to HIV prevention and are seven times[52] less likely to have a prescription for PrEP compared to White Americans.

Next-generation PrEP formulations, such as long-acting injectable cabotegravir, could be an important approach to providing HIV prevention during community reentry. However, people involved in the criminal justice system will not benefit from advances in PrEP if implementation of HIV prevention strategies within jails and prisons is not a policy priority.

The roadmap to ending the HIV epidemic goes through jails and prisons

Charting the course for ending the HIV epidemic must include county and state correctional facilities as stakeholders to successfully implement HIV prevention programs in jails and prisons. Non-medical HIV prevention strategies, such as condoms and clean needles, are supported by decades of evidence but have failed to become widely available in the criminal justice system. Without federal support and funding, HIV prevention strategies, such as MOUD and PrEP, will meet the same fate.

More than a decade[53] of research has demonstrated the feasibility and efficacy of HIV prevention in correctional settings. Today, incarceration continues to play a central role in accelerating the HIV epidemic. Failing to support evidence-based HIV prevention strategies in the criminal justice system reinforces racial inequity in HIV outcomes.

The updated HIV National Strategic Plan, which will define federal HIV policy through 2025, has opened the door to implementing HIV prevention services in jails and prisons by including an objective focused on increasing the capacity of correctional settings to diagnose and treat HIV. However, an additional step must now be taken to support the evidence-based implementation of PrEP and MOUD in correctional settings. Federal agencies such as HRSA and CDC should update their guidelines to incorporate PrEP and provide recommendations for integrating MOUD into HIV treatment and prevention services in correctional settings. Additionally, the Biden administration and Congress could support increased funding for implementation of HIV treatment and prevention in the criminal justice system.

The challenge of implementing MOUD and PrEP across the diversity of U.S. correctional settings is formidable and will require robust leadership, expertise, funding, and partnership at the federal, state, and local levels. The scope and suffering of the HIV epidemic demands action, and we must use every tool and strategy at our disposal.

FOR CITATIONS, go to the online version of this article: positivelyaware.com/prevention-in-justice-system.

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Adapted from an article that originally appeared on healthaffairs.org.

Shut your face

The best way to avoid HIV criminalization charges

BY ENID VÁZQUEZ

You cannot be white enough, you cannot be rich enough, you cannot be straight enough to not be misled by the police. The people at the Sero Project have even seen people living with HIV be forced on to a sex offender registry when no sex act took place.

"The number one thing we tell people when they call because they're afraid they might be charged is, 'Don't talk to anyone but a lawyer,'" says Tami Haught, managing director of the Sero Project, a national organization dedicated to ending HIV criminalization. "Even when talking to us, we say don't talk about your case. Just sort of tell us generally what's going on, because we don't want to be called as witnesses."

This includes information posted to social media and the internet seeking advice or information, including listservs. Anything you put online can be used against you. Anyone you talk to, online or in person or via text message or whatever, can be subpoenaed.

"Be careful of what you share. Don't disclose your status. Don't show your medication right away. Just ask for a lawyer because it takes so little to be convicted under state HIV criminalization laws, and the burden of proof is on the person living with HIV and not the prosecutor in many of these states," says Haught. "The cops can lie to you. Just keep saying, 'I can't talk without a lawyer.'"

One group of activists, the Colorado Mod Squad, has put together an HIV criminalization fact sheet in which they repeatedly say, "SHUT YOUR FOOL MOUTH."

The Sero Project trains people living with HIV, including members of the Mod Squad, to fight criminalization, as well as mass incarceration, racism, and social injustice. The organization runs an annual academy to train people living with HIV on policy making, grassroots organizing, and campaign planning. It's called the HIV Is Not A Crime National Training Academy (HINAC).

Depending on staff availability, the Sero Project might be able to connect people to lawyers in their area who can work on a criminalization case, or help with commutations and expungements. **EMAIL** info@seroproject.com.

So when you hear cops or other people say, "What's the problem with talking to the police if you have nothing to hide," here's the problem: You might say something you don't realize can put you in prison. Haught explains that, "With HIV criminalization cases, just knowing your status can get you charged and convicted."

GO TO seroproject.com.

SHUT YOUR FACE: EUROBANKS-ISTOCK

WRITING FROM THE INSIDE

Turn It Up!

Turn It Up! Staying Strong Inside is a zine-style wellness guide for people who are incarcerated. Published by the Sero Project in association with Prison Health News, the publication's two issues feature information about chronic health conditions, guidance on how to advocate for proper care while inside, wellness tips on staying healthy while incarcerated, and interviews. Most of the writers, artists, and interviewees have been or are currently incarcerated. Single or bulk copies can be ordered from The Sero Project, P.O. Box 1233, Milford, PA 1833, or via **EMAIL** info@SeroProject.com. **DOWNLOAD** them for free at stayingstronginside.wixsite.com/turnitup.

Black & Pink

Black & Pink (black for the anarchy flag, pink for queer power) is a social justice organization for LGBTQIA2S+ people and people living with HIV/AIDS, providing advocacy and support. Established in 2005, the group distributes a free national newsletter to LGBTQ people who are incarcerated.

"Black & Pink is an open family of LGBTQ prisoners and free world allies who support each other. Our work toward the abolition of the prison industrial complex is rooted in the experience of currently and formerly incarcerated people. We are outraged by the specific violence of the prison industrial complex against LGBTQ people, and respond through advocacy, education, direct service, and organizing," declares their mission statement. Write to Black & Pink, 2406 Fowler Ave., Suite 316, Omaha, NE 68111. **EMAIL** admin@blackandpink.org, or **GO TO** blackandpink.org.

‘She planted a seed’

Carla Davis couldn’t see the brightness of her future

INTERVIEW BY **ENID VÁZQUEZ**

JEFF RAMONE

“I would have never foreseen it several years ago when I first got diagnosed that this would be my life today,” says Carla Davis. “I’ve been happily married since 2011. I’m working with people and being a living testimony for people who have lived or are living the same struggle that I once did—you can’t ask for anything more.”

After receiving her HIV diagnosis while doing a 60-day stint in a prison in Illinois, Davis eventually followed up on a referral she was given for HIV care. There she met with a peer navigator. She would have never imagined that the woman helping her had once walked in her shoes. When Davis discovered that, it was a lightbulb moment. Davis recounts her journey, starting with the HIV test she took during a lockdown at Cook County Jail in Chicago.

“Originally, I didn’t think that testing positive was even a possibility. Not that I wasn’t doing anything risky. But just to show how uneducated I was, I really thought that I was able to look at a person and tell whether or not they were HIV-positive. So I just assumed that the people I slept with weren’t HIV-positive because by my standard, they didn’t look like they presented with HIV. So I go down and get tested just to get out of the cell, never thinking that my test will ever come back positive.

“It wasn’t like it is today. You can get a rapid test and get your results today. That’s not how it went. Two weeks later I got sentenced to the penitentiary and I hadn’t heard anything. So I thought that everything’s good. As they say, *no news is good news*.

“So I was down in Dwight Correctional [Center]. I was there maybe a week or two when I get a summons to report to the nurse’s station. The doctor said to me, *Is your name Carla?* I said yeah. He's like, *Did you take an HIV test at Cook County Jail in Chicago?* I said yes. He said, *Well, we just got your results and your test came back positive. We'll give you a referral. You can go back to your dorm now.* Just like that. No, *Do you need to take a moment?* I came in with trust issues. I came in broken, I came in feeling like the world is against me. And the last thing I needed was to have a doctor that didn't understand the depth of the fact that I just got diagnosed with HIV. I went back to my dorm thinking, *Oh my God. I'm gonna die. This is it.* This is not how I wanted to go.

"After that I didn't hear anything else. I just assumed that maybe they got the wrong person. I ended up getting transferred to Logan Correctional Center. I didn't hear anything there either.

"Then a week before I was going home they called me to confirm that I'm positive. This time they gave me a moment to calm down. The guy was like, *Just take however long you want.* Then two days before I left, they gave me a referral to the CORE Center [a medical facility in Chicago].

"Once I got released, obviously I didn't go directly from jail to the CORE. I was still in denial, so it took me several months. They assigned me to a peer navigator. She took me all around to all of the people I had to see—mental health, public benefits, the nutritionist, and then my doctor.

"I remember sitting in a waiting room, just terrified. My peer navigator looked at me and said, *You're scared, aren't you?* And I said, *Yes*. She said, *Don't be scared. I felt the same way when I walked through these doors several years ago, and they're going to take very good care of you here.*

"She didn't know the seed she had planted when she shared her story with me. Because when I first saw her I would have never thought that she was HIV-positive. I was still under the assumption that when you're HIV-positive, you die. You don't live a healthy productive life. Here she is healthy, gainfully employed, working to help other people who are newly diagnosed. And I was just like, *Wow, okay, she's not dead and she was diagnosed long ago.* She had been diagnosed about 10 years before I met her.

"I'm not going to say that as soon as I heard her story that my whole life changed. It was the seed that was planted that made me know that life is possible after being diagnosed with HIV.

"I went on several more years in my addiction going in and out of the penitentiary, and it just was fate. There was a God's blessing over my life. I came into the CORE Center one time and I was like, *I don't want to do this anymore.* You know, *I want to do what she's doing.* They had a program where you could sign up to become a peer. But one of the qualifications is you had to be clean and sober. I knew that some things had to change in my life in order for me to do that. So I went to treatment, and got clean.

"I met my husband, who at the time really didn't know a lot about what was going on with me. He just knew I kept coming to this place. And I knew that at some point I was going to have to tell him what was going on. He said, *That doesn't change how I feel about you. If anything, that makes me love you more. I want to take care of you.* That was one of the biggest issues for me. Who's going to ever love me knowing that I'm HIV-positive? And he was willing to take it on, telling me, *We're in this together.* That gave me even more of a push to do better. We just bought our first home in 2020.

"I was working part-time at the CORE Center and then I was offered the opportunity to work at Association House of Chicago [a nonprofit promoting health, wellness, and economic opportunity]. The catch was that the job was full-time. I was worried about giving up my SSI [Supplemental Security Income] benefit. What if things didn't work out? But the people at SSI explained to me that as long as I continued to report my earnings, that if anything changes, you can always get back on. So that was great. I could try out the job for a while and go back on disability if it didn't work out. I did HIV testing and outreach.

"While I was there, they allowed me to go to school and get my high school [GED] diploma while working full-time. The job actually required a diploma. But my supervisor, who hired me, said, *I see something in you. We're going to make sure you get that diploma.* I was the valedictorian of my class. There's no way I was supposed to get that job. I didn't have the qualifications.

"I ended up coming back to work at the CORE. Now I'm in college, working towards my CDC [Chemical Dependency Counseling] certification to become a drug counselor. It's been very stressful. But the friendships and bonds I've built have helped me.

"Today I'm the first line of defense, as we call it. I have a sit-down with new clients and I explain our case management and everything we have to offer. I just really talk with people and help them feel at ease.

"Then their case manager assists them with whatever their needs are, for example, getting a birth certificate, applications for SSI, finding day care and food vouchers, and connecting them with our employment specialists. If they're homeless, the case manager helps them find a shelter and gives them referrals for housing or Section 8 [federal housing assistance].

"Once all of that is taken care of, my job is to keep in continuous contact with them and verify that their needs are being met. I help continue an open dialogue and assure them that whatever they need, they can contact us. We now are able to enroll not only people who have a corrections background but also cisgender and transgender women who are newly diagnosed or who have issues keeping their appointments. I love my job.

"I think everyone in my life was strategically placed there by the hand of God. My supervisor at Association House and my mentors at the CORE Center always had a kind word for me and encouraged me. I am deeply grateful for the people who saw something in me that I didn't see in myself."

'When I first saw her I would have never thought that she was HIV-positive. I was still under the assumption that when you're HIV-positive, you die.'

The Women Evolving program is a collaboration of the AIDS Foundation of Chicago, the CORE Center, the Sinai Health Systems, and the National Alliance for the Empowerment of the Formerly Incarcerated (NAEFI).

One ACT UP arrest leads to a lifetime of perspective

Playwright **Lee Raines** looks at the 'justice' system

INTERVIEW BY ENID VÁZQUEZ

Playwright and actor Lee Raines had prepared with other ACT UP members for months for a huge demonstration in 1989. The brutality they faced that day showed him what the justice system does on a regular basis to communities of color and other groups that often face oppression.

"When doing civil disobedience, you go through trainings and you plan ahead," explains Raines. "This was a big demonstration on the second anniversary of ACT UP at City Hall [in New York]. You have all kinds of meetings about where you're going to get arrested, whether you're going to give your information over—all these things.

"I had been planning for months for my first arrest. The night before this demonstration, there was a big meeting which was kind of a pep rally. It was just hours after I had gotten my HIV diagnosis and that night I became obsessed with my blood. I worried, what if something happens and I bleed? Maybe I shouldn't do this. The guy I was venting to said, 'You know what, Lee? It doesn't matter if you get arrested tomorrow, but eventually you're going to have to go on living your life.' It was this unbelievably compelling idea that was presented at this unbelievably compelling moment in my life. And so, I went through with it.

"The arrest was more brutal and horrific than I ever imagined. Most people were getting arrested for blocking traffic near the Brooklyn Bridge. Our group went around to another side of City Hall. We hopped across a fence and walked across the lawn. Our idea was that we were going to present our demands on the steps of City Hall or as close as we could get. As we approached, there was a line of policemen with machine guns. So we sat down in a circle and shouted our demands and waved our papers, and the police came and started handcuffing us one by one around the circle. At first it seemed very professional. Then as soon as the last person was handcuffed, the police turned into monsters with horrible eyeballs bulging, red-faced, and homophobic—screaming at us, 'You're all gonna die. You have AIDS.' They were throwing us into the van and saying, 'Break their fucking backs. They're all gonna die anyway.' It was a mob of police shouting this kind of invective at us the whole time. They were throwing us over the fence in a way that when we landed we could break our bones. So we were scrambling to protect the people being thrown in after us because it was so dangerous. It was brutal.

"Being inside changed my whole world view in a lot of ways. But I realized, as I came out, that being in jail was not so bad for me because of the way it was set up. I knew that I was in a relatively controlled environment. I had made the decision. There were people on the outside waiting who knew I was in there. They had separated us from the general population. The women who were arrested won a lawsuit because everybody had had a body cavity search. That arrest was very intense for everyone. What I experienced was daily life for half the people in America. It forever changed how I felt about how the U.S. is policed and about systemic racism. This realization came that as bad as it was for me, it was a sliver on a window to the experience of half the people in America," says Raines, choking back tears.

Last year, Raines wrote the play "Blood Spill," a dark comedy about living with HIV, as part of playwright Donja R. Love's "Write It Out!" workshop for writers who are living with the virus (see "Briefly," November+December 2021). Afterward, Raines was commissioned by the Elizabeth Taylor AIDS Foundation to write "Unjust" (see next page for an excerpt).

"The Elizabeth Taylor AIDS Foundation has produced testimonials of people who were incarcerated under HIV criminalization," says Raines. "It really is a fantastic way to present the information. The laws are changing because of the work done for decades by the Positive Women's Network-USA and the Sero Project. You go to a health conference and hear a speech or you hear the testimonials, and the information is so painful. It's hard to hear. It's easier to sit in a seat and watch fictional people in a play. I think the fact that it's fictional allows you some distance and allows you to take in this painful difficult subject in a different way. It can even be a way to get people to listen to a story they may otherwise not be interested in. I think the Elizabeth Taylor AIDS Foundation came up with a great way to bring people in and get them into the seat and be open to listening to these stories." PA

RAINES COURTESY THE ELIZABETH TAYLOR AIDS FOUNDATION

‘Unjust’

An excerpt from Lee Raines’ 10-minute play

A morning TV talk show in New Jersey, with guest George Ratliff, retired prosecutor and former state and U.S. senator, promoting his new memoir.

CO-HOST RENATA VEGA: Good morning, Trenton! I’m Renata Vega.

CO-HOST RAY TAYLOR: And I’m Ray Taylor. Together we’re . . .

VEGA AND TAYLOR (TOGETHER): Renata and Ray, starting your day!

...

TAYLOR: Speaking of regrets, there is one passage in your book I’m curious about. It’s about your zealous, some say overly zealous, prosecution of crimes related to HIV. Your prosecution of HIV-related crimes was unyielding to say the least. In 1993, you argued to give Darnell Jackson, age 23, the maximum sentence of 15 years, for allegedly biting and spitting at a police officer. There was no transmission of HIV, and no marks on the officer, but Mr. Jackson was convicted of attempted murder, aggravated assault, and making terroristic threats. For someone who was HIV positive at that time, 15 years was a death sentence.

RATLIFF: He didn’t serve the entire sentence.

TAYLOR: He was released after six years for exemplary behavior. But he was labeled a sex offender, a status that makes it enormously difficult to find a job, housing, he’s identified to his neighbors, he can’t go near schools, he can’t even be in a room alone with his nieces and nephews without another adult present. His life was ruined.

RATLIFF: Mr. Jackson was lawfully prosecuted according to the laws of this state. You have to remember the context. At the time those laws were written, emotions ran very high, very high. There were no drugs. No medications. If you were infected, it was a death sentence. I explain all this in the book. Yes, the penalties were harsh, but I was enforcing the law as written.

TAYLOR: Which brings me to the issue of HIV-specific crimes. If you could put people away for decades with laws that were already on the books, why did you make it your mission to pass a whole series of new laws specific to HIV? It was previously unheard of to pass laws specific to a particular medical condition.

RATLIFF: Those laws were written in a time of great panic. And it wasn't just Jersey. A lot of states passed similar laws. The public demanded them.

TAYLOR: But when the panic subsided, when medications became available, the laws were recognized as onerous, and bills were introduced to lessen their severity. You voted against them.

RATLIFF: That's misleading. I wasn't a state senator every time those bills were introduced.

TAYLOR: As a state senator, you voted against two decriminalization bills. As a U.S. Senator, you had the power and the voice to influence votes on subsequent bills. Yet you said nothing.

RATLIFF: You can't expect me to remember every vote on every bill.

TAYLOR: Sir, you agree the laws were written in a time of hysteria, but you've done nothing to correct them. HIV specific laws are still on the books in 30 states. New Jersey's carry some of the stiffest penalties in the country.

Other states have modernized their laws to meet current science. It's a shameful, tragic irony that the first state in the country to ratify the Bill of Rights tramples so heavily on the rights of people with HIV. I have a personal stake in this fight and I'm asking you to help right these wrongs.

RATLIFF: I don't have the power to rewrite every law I disagree with, Ray. I'm not even in office.

TAYLOR: Your book is on the best seller list. You're on a speaking tour. You could say something. Your book contains only a tepid expression of regret over a case where a boy was sentenced to 15 years in prison in a case with no transmission of HIV.

RATLIFF: He was 23! He wasn't a boy! And he was threatening police officers!

TAYLOR: The boy had been severely beaten. And biting and spitting does not transmit HIV.

RATLIFF: The officers didn't know that!

TAYLOR: They should have! And you did know! You knew it very well.

VEGA: Sir, these laws are horrendous. The laws in New Jersey don't even require transmission of the virus. You don't even have to prove intent to cause harm. Without transmission, or intent to harm, how is there a crime? No one is harmed, but they can still be found guilty? How is that fair?

RATLIFF: You're leaving out a key element, Renata. These people didn't disclose their status. Why can't they just disclose?

VEGA: In a perfect world, that would be an easy call. In a perfect world, people would be honest and good, everyone would have access to health care, nobody's job would be at risk, and having HIV wouldn't carry stigma. That's not the world we live in. Especially women. Senator, you have this idea in your head that it's so easy to disclose. But for every reason to disclose, there are a hundred reasons not to.

And one major reason is these laws. They're counter-productive. They're a reason to not get tested, because if you don't know your status, you don't have anything to disclose.

RATLIFF: None of this has been proven to my satisfaction.

VEGA: Just think about it! Why would anyone give a person they're dating so much power? They can tell your neighbors, your family, your job, your church, social media, any random stranger. They could ruin your life, and put you in jail for years. You have no idea what it's like for people like me. For people in my community. In my own family. You don't know, and you're not even listening.

You don't know what criminalization does to families. In your world, people get in trouble, daddy makes a phone call, some high-priced lawyer makes it all go away. In my world, people make mistakes, but for us, scraping together three thousand or five thousand dollars for a lawyer is impossible, even if the whole family chips in. And these days, five thousand dollars buys you a crappy lawyer. So for years and years, there's an empty seat at the dinner table. At every family event. Do you have any idea what that's like?

RATLIFF: Yes, I do.

VEGA: Okay, but in my situation, Senator, family members start blaming each other, and everyone chooses sides, and we get angry, and feel guilty, and get upset that nobody came up with the money, and every family holiday is full of tension and anger and sadness. And even after they get out, these people feel shame and regret, and sometimes they move away, or become estranged, or spiral down and our families are left with loss. Terrible loss. We don't just lose a person, sir. We lose part of the fabric that holds our families together.

You ask, "Why don't they just tell them their status?" Because telling one person could mean the whole world finding out.

FROM LEFT: Catherine Brown, executive director of the Elizabeth Taylor AIDS Foundation (ETAF); Robert Suttle, chair of ETAF's Council of Justice Leaders; activist Andre Leaphart, Diana Oliva, of Gilead Sciences; and Jake Arman, ETAF program manager at a December 2021 performance of "Unjust." The play was commissioned for ETAF's HIV Is Not A Crime initiative. **GO TO** hivisnotacrime-etaf.org. Suttle appears in a testimonial video as part of the True (Not) Crime series directed by Zachary Quinto at bit.ly/Suttle-HINAC-video.

ELIZABETH TAYLOR AIDS FOUNDATION

Living post-traumatically

A note about identification: Although nearly all of the writers who are currently incarcerated gave permission to have their full name and address included, POSITIVELY AWARE was advised to print only their first name and their state. PA will forward mail to them as is possible; incarceral systems often have complicated rules for communications. We apologize to the writers.

Poems by a woman on death row

BY **VICTORIA**

I am a 40-year-old transwoman on Ohio's death row. I've been a huge advocate and voice for trans and HIV-positive inmates in prisons basically all my adult life. I enjoy the opportunity to network with other like-minded people.
—VICTORIA, OHIO

Untitled

Born in captivity mentally
Inside my transgender identity
Eventually it manifests physically
Stripping my true femininity
Imprisoned in forced masculinity
In prisons and state penitentiaries
Every day my safety in jeopardy
With no one but me there protecting me

Insecurities ate at me constantly
Economically raised up in poverty
With thoughts continuously taunting me
And dreams seem to always be haunting me
Sexuality became a commodity
My body just traded like property
Like the cheapest spots on Monopoly
Unaware what it actually costed me

My biography lived post traumatically
Systematically the system's attacking me
Statistically supposed to die tragically
Most likely some transgender casualty
Surrounded by such inhumanity
The enemy threatens my sanity
HIV threatens to banish me
As I fight for those who come after me.

The Row

The road that we stroll
The price on our head
The ropes on our throats
Like yokes on our necks
Like the edge of a ledge
We choke on the smoke
Of the lives that we've led

Broke down from the load
And the crowns on our head
With the boulders we hold
On our shoulders and neck
It's cold on the Row
Alone as we thread
Taking toll on our souls
As hopelessness spreads

An oath to the ghost
Of the dead in my head
I know what is owed
For the tears that were shed
The lives that were stole
The pleas that were pled
'Tis my ode to the souls
For the blood that was bled.

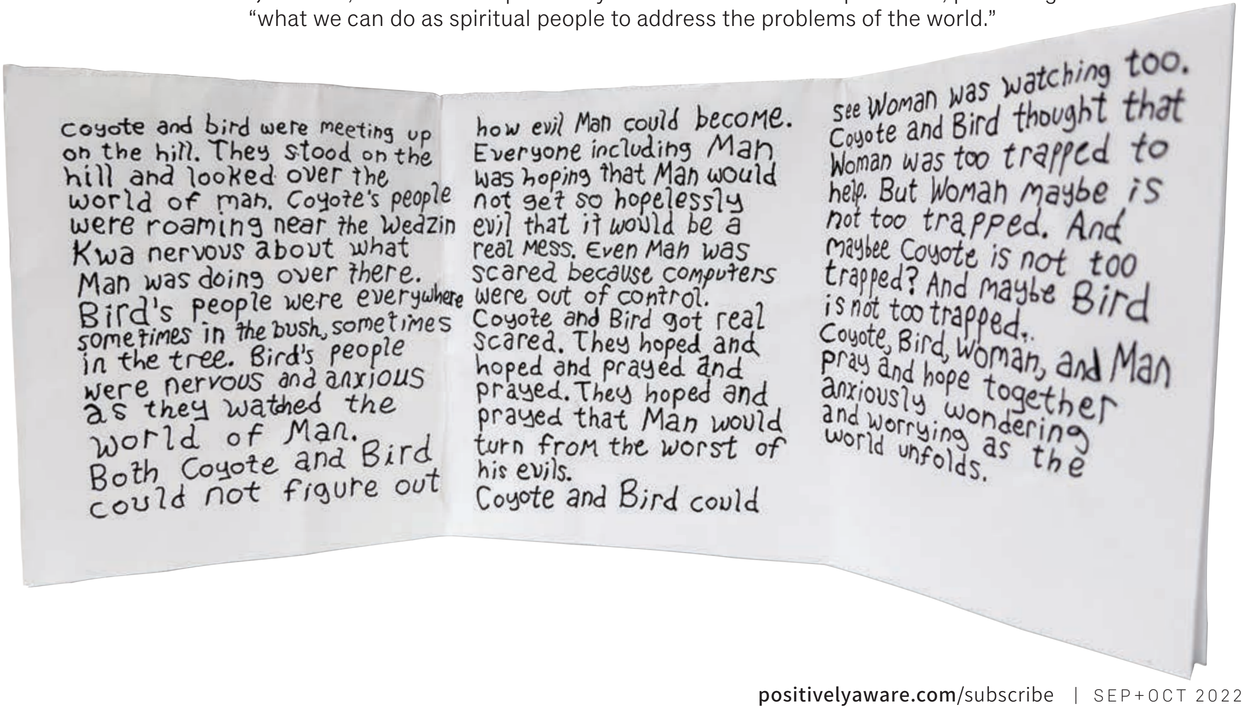
Beyond Death

Not enough doses,
To cope with emotions.
Live every day hopeless,
Just go through the motions.
I try to stay focused,
When everything's broken.
And everyone's bogus,
Hearts frozen and soulless …

I know what defeat is,
I know what a creep is.
I know how it feels,
When they feed off your
weakness.
Ate crumbs with some bums,
I know what the street is.
Fight demons with demons,
I know what for keeps is …

Nowhere left to hide,
No tears left to cry.
The pain still remains,
The rain won't subside.
I take life in stride,
No fear in my eyes.
I'm sentenced to die,
As if I'm alive.

Coyote Christians Contemplate Modern Man **(2022)**
—**PAUL, ILLINOIS**, who has been previously incarcerated and is on probation, pondering "what we can do as spiritual people to address the problems of the world."



coyote and bird were meeting up on the hill. They stood on the hill and looked over the world of man. Coyote's people were roaming near the Wedzin Kwa nervous about what Man was doing over there. Bird's people were everywhere sometimes in the bush, sometimes in the tree. Bird's people were nervous and anxious as they wathed the world of Man. Both Coyote and Bird could not figure out

how evil Man could become. Everyone including Man was hoping that Man would not get so hopelessly evil that it would be a real Mess. Even Man was scared because computers were out of control. Coyote and Bird got real scared. They hoped and hoped and prayed and prayed. They hoped and prayed that Man would turn from the worst of his evils. Coyote and Bird could

see Woman was watching too. Coyote and Bird thought that Woman was too trapped to help. But Woman maybe is not too trapped. And maybee Coyote is not too trapped? And maybe Bird is not too trapped. Coyote, Bird, Woman, and Man pray and hope together anxiously wondering and worrying as the world unfolds.

Separation

Stigma upon stigma adds to one man’s sentence

BY **E.C.**

Twenty-two years have passed since the fateful day that inducted me into a family of those who have felt lost, alone, and rejected. Discovering that I was positive altered my life in a way that is still at times unfathomable. Understanding how to live with the stigmatization that three letters would control how I lived for the rest of my life was the hardest obstacle I would ever face. Or so I thought.

I don’t have to deal with that horrendous feeling when someone will get

Eighteen of these years I have been incarcerated in the Florida Department of Corrections, where I am serving a 40-year sentence.

Incarceration is an austere, lonely existence. Designed to create a world that is cruel, where the separation from society is a far greater punishment than that of penal servitude alone. Couple that with being positive, then compound it by being gay, and life becomes even more complicated, depressing, heartless to a point where you feel so ostracized that you’d rather die. Rejection is the worst kind of feeling for anyone to endure, even more so when you are incarcerated.

Positive persons have previously lacked acceptance and have often been viewed negatively in the past by our society at large. Now imagine another type of society where the acceptance of being positive is practically non-existent, a world all to its own with insulting lingo, jokes, and ignorant ideas about people who happen to live with an affliction that is no different from being diabetic or diagnosed with cancer. When you are positive behind the walls there’s a great deal of branding that is nearly impossible to overcome. What little information is available falls under the direction of drug treatment courses and transition programs, where HIV is only mentioned in barely more than a paragraph. This does little to alleviate the thinking and labeling that is persistent on the inside. For as many strides toward acceptance the outside world has made, the incarcerated community lags too far behind.

Within a few years, half of the population in Florida’s criminal justice system will be over the age of 50. By then the majority of these incarcerated persons will have been behind the walls for more than a quarter of a century, many venturing into over 40 years. With this type of population that has little or no education pertaining to the virus, their attitude about HIV is like living in the 1980s all over again. Those who are positive “got that shit,” or the “ninja” got them. We are all expected to die, and to die a horrible death. And for those gay persons who aren’t positive it’s just assumed that because they are gay, they have it also. So many jokes are cracked pertaining to the virus that this continues to heighten irrational thinking and stigma of the virus. When one is cold, “T cells are low.” If one loses weight, they’ve got “that ninja,” and on it goes to no end. As I listen to the guys around me I cannot help but wonder what they would think if they knew that I was positive. By no means do I ever lie about my status. If I am ever questioned I don’t lie or even skirt the issue, I am open and honest. I owe that to myself and everyone who is positive not to be a fraud. Rarely have I been asked; I figure that most don’t really want to know. I do fear the backlash of what could possibly happen if my positive status were to become common knowledge. It’s being rejected that causes me fear; I’ve been rejected enough in my life that I don’t want to continue down that path any longer. I’d love nothing more than to be so honest about my status that I am able to use it as a platform for education, prevention, and a living testament that you can overcome obstacles so great in your life that you will survive. At this time I cannot.

At my current camp, the stigma is so great that we nearly all live in fear of being found out. Certainly I am not the only positive person here, yet no one seems to be so open that it’s common knowledge. We do all see the same doctor, but we don’t speak of it, just a knowing nod if we happen to have an appointment the same day and then we go on about our business. In prison, when you know something, you actually never know. This is like belonging to some secret society that is taboo to speak of in public. There are days that I long to have someone to speak to about side effects, survivor’s guilt, the ups and downs of life, or just

THOMAS SHANHAN-ISTOCK

up and leave the table just because they don't want to sit with a "queer."

the depression that comes with it. To confide in anyone else who is positive and can understand how I feel. But I have learned to deal with these obstacles, to be resilient in the face of possible rejection.

Already I am ostracized to an extent by my homosexuality. The fact that I am gay is accepted by the majority of my peers but this is only to a degree. As long as I am not within the inner circle of those with issues I am of no concern to their daily life. I am simply in the background. But there are issues that can make life difficult for me at times. The showers are open with no dividers, much like a locker room setting, where people are so fearful of either my "gayness" or, if they aren't bothered, they are worried about what others would think if they were seen in the shower with me. At times I will sit alone in the dining hall. When I enter, I automatically look for an open table. That way, I don't have to deal with that horrendous feeling when someone will get up and leave the table just because they don't want to sit with a "queer." So, can you imagine the fear that I have inside if people were to find out that I am not only a homosexual, but positive? It's unnerving to say the least, causing me a great deal of stress.

Prior to my current camp, I was housed at an institution where I was able to be extremely open and honest about my status. I came to be respected for my honesty and ability to show people that someone living with the virus is no different from any other of the incarcerated community. During that time I was able to share my struggle and story with my peers in order to educate them, doing my best to have them understand. This of course was a great stumbling block to overcome. It took me years to be comfortable enough to put myself out there. In the end I felt rewarded for my honesty, because some came to a better understanding of how the life of a positive person can be. I was even asked to address two different classes about how my life changed after diagnosis and where life has taken me since. Perhaps I made a difference in someone's life. Not everyone succumbed to my charms, many still held on to the stereotype they have always had about positive persons. Times change, transfers occur and I am currently where I am.

It saddens me that I can no longer be that open. There are times I just want to scream that I am no different from others. Does no one understand this? Unfortunately, they cannot get beyond their own ability to stigmatize.

Finding acceptance as a positive person is the greatest encumbrance to an incarcerated individual, one that is nearly impossible to counteract given the thinking of my peers.

Though acceptance is an enormous obstacle, one where I'm left feeling hollow and unwanted, life as an incarcerated person isn't completely dismal for me. As I have progressed with my virus I have also grown as an individual. Over these years I have found hope, a hope those 22 years ago I thought I would never have. With only two shots a month I am able to go about my life as if I'm as normal as anyone else, coming to a place where HIV isn't a daily reminder.

Perhaps in the future my peers will come to a place of countenance for persons who are positive; where they too will not think of people only in terms of HIV. Anticipation for this moment is tremendous for me. We are all a part of this world; each and every one of us is different and special in some way. Being positive is simply one aspect of that uniqueness. Positive individuals have just as much to offer the world as anyone else. PA

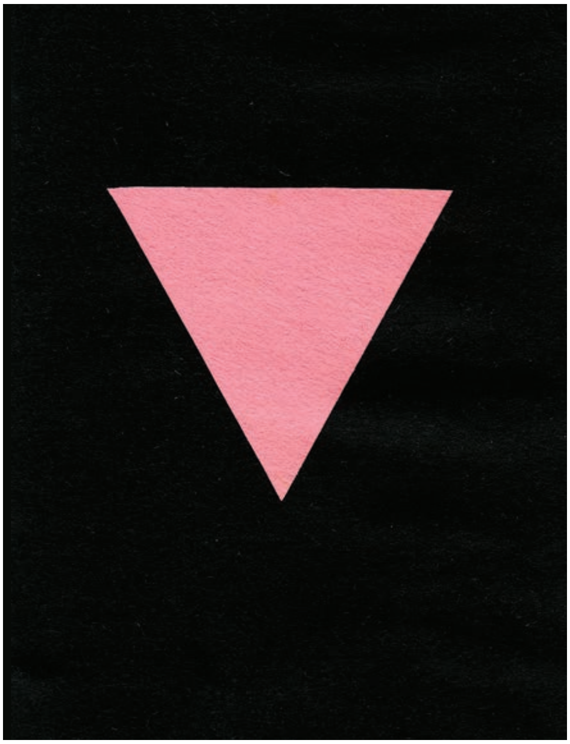
Learning and teaching

In a letter to POSITIVELY AWARE, E.C. in Florida wrote: *Your publication has been a part of my life and taught me so much, for a great many years. Due to the information provided in PA, clinicians speak with me as an equal. They're rather surprised at the knowledge I have. That's how my current clinician let me have Cabenuva without the oral lead-in. He says I'm "sophisticated." In DOC [the Department of Corrections], they prefer the lead-in oral dosage as it's easier for possible side effects. Life is different in here.*

‘Justice-involved’ is not always just

Readers write about being inside

COMILED BY **ENID VÁZQUEZ**



ACT UP artwork

Thank you for everything that POSITIVELY AWARE does for the community.

—HANDMADE CARD (ABOVE) SENT BY **WILLIAM, WEST VIRGINIA**

‘Justice involved’ is not just

Thank you for being sensitive to the plight of the incarcerated for using a seemingly politically correct term as “justice involved.” Frankly, it is not a term any consciously aware imprisoned person would use. As a gay man who’s been unjustly incarcerated in California for 20 years, on charges for which I am not guilty, I will tell you that there’s absolutely nothing “just” about *their* so-called “justice.” It remains the same good ol’ boy system, essentially unchanged since the days of slavery. We are dealing with an *injustice* system which is blatantly evil, and so I call for the use of terms which more accurately reflect the truth of the matter instead of always attempting to acquiesce and sanitize it.

—CHRISTOPHER, CALIFORNIA

Associate Editor Enid Vázquez responds: Bless you. I have hated the term “justice involved” from the first time I heard it. Language changes over time and we get better at it. So thank you for starting this conversation. Please stay in touch and help keep us on the right path.

Living

I had to write concerning HIV in prison. I have a positive and a negative message.

Marion County Jail neglected to give me my HIV meds for five and a half months of my seven-month stay at their fine facility. By the time I was sent to prison, I was in the AIDS range. I’m looking for a lawyer to help me. *I need one*, if possible.

On a positive note, by the time I was sent to prison and put on the proper meds for my HIV progression, I saw my levels starting to decline. Within a year, I was back to undetectable and gaining weight.

People incarcerated can thrive with proper help and resources. Taking our meds is so important and I thank god we have access to them.

Still alive.

—KATIE, FLORIDA

Saving lives

I am writing to request that you please ensure I have an active subscription to your periodical. I am an HIV-positive prisoner in the Colorado Department of Corrections and depend on your publication to stay current with my healthcare. I appreciate your generosity! It saves lives.

—MICHAEL, COLORADO

Wake up, youth

I am an incarcerated convict of 28 years in the Florida Department of Corrections, where there is no parole. (Parole was abolished in Florida in 1983). Every life sentence is a natural life sentence.

I have been in prison since I was 22 years old and now, I am 50. But early on into this bid, a fellow convict turned me on to POSITIVELY AWARE as an educational tool, and ever since I have been reading it and a part of the POSITIVELY AWARE family. The knowledge, wisdom, and understanding PA has given me of infectious diseases and treatments is *gold*.

Sad to say, we have had a youth explosion in the Florida prison system in the last 10 years, and when it came my turn to pass POSITIVELY AWARE on to the next generation of inmates, the youth were not as receptive. Somebody had spread the word that POSITIVELY AWARE was an HIV magazine, or that HIV was strictly a gay disease. Since the majority of Florida youth prisoners are in some type of gang, they were scared to death to risk getting violated by their gang over reading the magazine. Well, two or three fights later, two or three hundred arguments later, here I stand writing this to the youth of the Florida prison system: *Wake up!*

—ANTHAWN, FLORIDA

Editor’s note: We think “violated” as used here means given a penalty.

A Day with HIV

I am a subscriber to TPAN and I greatly appreciate the information and HIV/AIDS education and awareness highlights.

TPAN has greatly aided me in doing my part in educating buddies and cellies on HIV/AIDS care, risks and treatments as well as trying to curb the ’80s and ’90s stigma of being poz.

I have been positive for 28 years and I’m 45. And being a gay man in prison is difficult enough and much more so being poz. But with the help of the articles and scientific proof I have used TPAN to battle the early epidemic stigma and mentality of other offenders here in prison in 2022.

Enclosed is a photo I’d truly love to be added to A Day with HIV [POSITIVELY AWARE’s annual anti-stigma campaign]. I’m just hanging out with a friend. I am on the right. Always open about who I am—a strong, open and informative survivor of life who just happens to have HIV!

I greatly appreciate all you and TPAN for everything. Thank you!

—JOSHUA, MISSOURI

Not a felon, but a human being

Using words to help set people free

BY **ENID VÁZQUEZ**

To call someone a “felon” or an “ex-con” is to negate their humanity. They are a human being first and foremost. That’s why the use of people-first language is important.

With people-first language, a person’s humanity comes before any label. So someone may be a person with a felony conviction. They are a person first, however, not defined by the conviction.

Today, for example, we say “people living with HIV,” not “HIV-positive people.” It’s not the HIV positivity that’s the defining identity. HIV is simply a part of who the person is. It shouldn’t come first.

Labels focus on only one aspect of a person’s life. Sometimes it’s an undesirable or stigmatized label. Instead of seeing someone as *being* “disabled,” for example, we can think of someone as *having* “a disability.”

Other words matter, too. Why say “suffers from disability” instead of “has a disability”?

> **Labels focus on only one aspect of a person’s life. Sometimes it’s an undesirable or stigmatized label.**

Rather than say “slave,” we now say “person who was enslaved.”

A person can commit an illegal act, but human beings cannot themselves be “illegal,” as activists and advocates tell us.

The word “visit” can apply to children visiting a parent who is incarcerated. “Visitation” is a term used by bureaucratic systems.

One language guide suggests saying, “people convicted of felonies,” not felons. People convicted of crimes, not criminals or convicts. People who have committed offenses, not offenders or perpetrators. People accused of a crime, not defendants. People on parole, instead of parolees. Children or young people instead of juveniles. These suggestions come from the Criminal Justice Reform Phrase Guide of The Opportunity Agenda, under “People, Not Labels.”

In their guide “Why Language Matters,” The Well Project, a nonprofit organization that focuses on women and girls living with HIV, notes that, “Using inappropriate language to describe HIV and women increases the amount of stigma and stress women experience daily. Putting the label before the person, as in the phrase ‘HIV-infected woman’ or ‘HIV-infected mother,’ dehumanizes women and turns them into a disease or illness. Instead, the preferred phrase is ‘woman living with HIV’—referring to the person first, before mentioning their health condition.”

Instead of calling it a *death sentence* and *fatal* or *life-threatening condition*, the guide says, “HIV is a chronic and manageable health condition as long as people are in care and treatment.” In other words, stop using those scary (and outdated) words. “Never use ‘infected’ when referring to a person.” (Pretty much avoid the word “infected”—*period*.) Use “new transmissions” instead of “new infections.”

The guide recommends instead of using words such as “prostitute” or “prostitution,” say sex worker, sale of sexual services, or transactional sex. Instead of “promiscuous,” multiple partners.

In “Words Matter: Using Humanizing Language,” The Fortune Society, an organization dedicated to people who are or were formerly incarcerated, notes, “Dehumanizing labels stereotype and marginalize people rather than support them while they rebuild their lives. Individuals with justice system involvement are not defined by their conviction history. The words we use to reference people should reflect their full identities, and acknowledge their capacity to change and grow.”

Words to be avoided include offender, inmate, felon, criminal, convict, prisoner, and delinquent. Also, ex-offender, ex-con, ex-prisoner, parolee, probationer, and detainee. Say instead “person or individual on parole” and “person or individual on probation,” and “person or individual in detention.” Instead of “homeless,” say “person currently or previously experiencing homelessness.” Instead of addict or substance abuser, say “person with a history of substance use.” (Similarly, say “substance user” and avoid saying “abuser.”)

The community of people living with HIV and their allies is heavily burdened by stigma. It’s a continuing battle for respect. Even self-respect—how people treat you can affect how you treat yourself.

FIND many resources on people-first language and incarceration at osborneny.org/resources-for-humanizing-language. **READ** “Why Language Matters: Facing HIV Stigma in Our Own Words,” at thewellproject.org/hiv-information/why-language-matters-facing-hiv-stigma-our-own-words. **DOWNLOAD** a PDF of the NIAID (National Institutes of Allergy and Infectious Diseases) HIV Language Guide at bit.ly/NIAID-HIV-language-guide.

Rising above negative expectations

“At The Fortune Society, we frequently say ‘the crime is what you did, it’s not who you are’ because it’s important for people who have been in the system to remind themselves that they have an opportunity to move forward. **No one wants to be judged into perpetuity** for their bad decisions and no one wants to be branded with a scarlet letter.”

—**Ronald F. Day, PhD**, vice-president of programs at The Fortune Society in New York City. “As someone who spent 15 years in prison, I know that a simple but effective way to help reform the system is to refrain from using negative vocabulary, words and terms like ‘felon,’ ‘ex-con,’ or ‘inmate,’ wrote Dr. Day. “Indeed, if we want to be a country that truly believes in second chances, we need to remove this negative stigma.” **READ** his essay at bit.ly/fortune-society-words-matter.

Monkeypox Q&A

HIV specialist **Peter Shalit** answers some essential questions

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What is monkeypox?

Monkeypox is an illness caused by a virus closely related to the smallpox virus. Despite the name, these viruses are not related to the chickenpox virus, which is a herpes virus. I know that's confusing. Just think of monkeypox and smallpox as their own unique type of virus.

Historically, monkeypox has mostly infected animals in Africa, with an occasional spread to a human. However, this year's epidemic is a new development. The virus has escaped from its usual animal host and is now spreading from person to person. In particular, it has entered the sexual networks of men who have sex with men, and is increasing among that group, although there are also a smaller number of cases occurring in other people.

What are the symptoms of monkeypox infection?

The virus causes blisters or pustules ("poxes"), which can be very painful. These can appear anywhere on the body. In the current epidemic, they also are commonly found in the "underpants zone," namely the genital and anal areas. They can also cause swelling and pain inside the anus. People infected with monkeypox may also have fever, muscle aches, headache, cough, swollen lymph nodes, loss of appetite, and other symptoms. People with monkeypox are generally ill for 3–4 weeks and are advised to quarantine to prevent further transmission. In the past, an occasional person has died from monkeypox. In the current epidemic, no one in the U.S. has died of monkeypox, but some people have required hospitalization for pain control or other symptom treatment. So far I am not aware that the disease is worse in people living with controlled HIV, but there have not been enough cases yet to tell that for sure. The disease does seem to be worse in people whose HIV infection is not controlled.

How is monkeypox spread?

Most commonly this virus is spread by skin-to-skin contact, such as during sex, especially via contact with the fluid from one of the pox lesions. The virus can be detected on inanimate objects such as sex toys, towels, and benches, so it could theoretically be transmitted via one of these objects if it was in contact with someone with active monkeypox infection. However, it is likely that the virus detected on these surfaces is not very infectious. Monkeypox may also be transmitted by respiratory secretions and by body fluids such as semen. Close intimate skin-to-skin contact, and especially penetrative (oral or anal) sex, seem to be the most common ways it is transmitted, as opposed to simply being in the same room as someone, or casual contact with another person's skin or a surface they have touched. However, because of the risk of transmission, a person with monkeypox is asked to physically isolate from other people until they have fully recovered.

Is monkeypox a sexually-transmitted infection (STI)?

I consider monkeypox to be a new STI, since almost all cases can be attributed to sexual contact, almost exclusively male-male contact. In fact, in a recent analysis of the first 528 monkeypox cases in the current epidemic, 95% were attributed to male-male sexual contact. Many of the cases are being diagnosed in sexual health clinics, where they may be misdiagnosed at first as a more typical STI such as herpes or syphilis. In some cities, sexual health clinics are taking the lead in addressing the epidemic. This is why I think it's useful to frame monkeypox as an STI among gay men, even though a small minority of cases are occurring in other people, mostly from non-sexual transmission. These rare non-sexual cases do not seem to lead to additional spread. Almost all of the ongoing spread can be attributed to sexual contact.

Also, just "being gay" does not put a person at risk of monkeypox; rather, it's whether you are sexually active and who you have intimate contact with. This is important as I have had some gay male patients, who are not sexually active at all, express a (mistaken) fear that they are at risk of getting monkeypox. It is not how one identifies; it's what one does intimately, and with whom that exposes a person to this virus.

How does a person get tested for monkeypox?

A health care provider swabs the fluid from a pox lesion and sends the swab to a lab for testing. This test is now available via large commercial labs in the U.S. There is no self-testing yet, and there is no blood test. A person must have at least one pox lesion in order to be tested. In that case, they should go to a health care provider—either their primary care provider, a walk-in clinic, or sexual health clinic, etc. Clinics that typically see men who have sex with men are more likely to be up to date on how to obtain and send a specimen for testing.

How can monkeypox be prevented?

The most surefire way would be for a man to not have sexual contact with new male partners for the time being, since the virus is circulating primarily among men who have sex with men, and by intimate (often sexual) contact. That's impractical on a large basis; sex and intimacy are powerful human drives. However, I take care of some men who are normally very sexually active, but who have decided lately to pause their sexual activity or tighten their sexual network for the time being, given the risk. Short of that, it's helpful to know who you are intimate with, whether they have a rash or other symptoms, or have been ill recently. Sex clubs, sex parties, and other similar settings pose a high risk of infection if a participant has this virus.

There is also a vaccine, JYNNEOS, that is effective at preventing monkeypox (and smallpox). The vaccine is given as a shot under the skin of the upper arm (subcutaneously), or at a smaller dose between layers of the skin (intradermally), in the lower arm. A second dose is given a month later. People tend to have minimal aftereffects from the vaccine although the newer intradermal way seems to cause more local irritation. Protection is said to start two weeks after the second dose. Although it is a live vaccine, JYNNEOS appears safe for people living with HIV, at least if their CD4 count is over 200. In fact, the vaccine was studied in this population and no problems were found. It has not been studied in people with untreated HIV and/or CD4 below 200. When a person has a weakened immune system, some live-virus vaccines can spread uncontrolled in their system and cause illness. However, even though JYNNEOS contains a live (but crippled) virus, it is probably safe in such folks. The virus in the vaccine has been genetically altered such that it theoretically is unable to spread within the person's body, or be transmitted to another person. A live vaccine approved for smallpox, ACAM2000, is also available and should give protection against monkeypox; however, it is much more toxic, can spread within the body and to other people, and it should not be given to people living with HIV.

JYNNEOS can also be given for post-exposure prophylaxis. If a person has had close/intimate contact with someone who proves to have monkeypox, the person can get a dose of vaccine. If given soon enough it may prevent the infection completely, or (especially if given more than a few days after exposure) it still may make the infection less severe.

The supply of JYNNEOS is very limited, although much more will be available over the next few months. It is being distributed by the CDC and local health departments, and from there to clinics where it is given to patients. Currently in the United States the supply is allocated to cities and counties based on the number of cases there. This does not account for the fact that many people travel. In particular, gay men traveling to an event such as Bear Week in Provincetown, or going on a gay cruise, may have difficulty getting a dose before they leave if they live in an area with few cases.

"I am 'older' and I had the smallpox vaccine when I was a child, which younger folks have not had. Will this vaccine protect me from monkeypox?"

We know that the immunity from smallpox vaccine fades with age. The smallpox vaccine that some older folks had decades ago is unlikely to prevent monkeypox now. However, it may help reduce the severity of the disease if the person catches monkeypox.

How is monkeypox treated?

Most people with monkeypox do not need antiviral treatment; their system clears the virus on its own. The most common treatments a person might need are for control of symptoms such as pain and fever. There is an experimental antiviral (tecovirimat, or TPOXX) that can be obtained for people with severe symptoms. This is not available at regular pharmacies and would have to be accessed through the local health department, infectious disease clinic, or other clinic that has been authorized. HIV antivirals do not treat monkeypox, nor do antivirals designed for other infections such as herpes, flu, and COVID-19.

PETER SHALIT, MD, PHD, is an internal medicine physician in private practice in Seattle, Washington, since 1990. He shares his LGBTQ-focused practice with two physician assistants, caring for a large diverse group of adults of all ages, gender identities, and sexual orientations, including many people living with HIV and a similar number of folks on PrEP. His clinic also participates in clinical trials of HIV treatment and prevention medications.

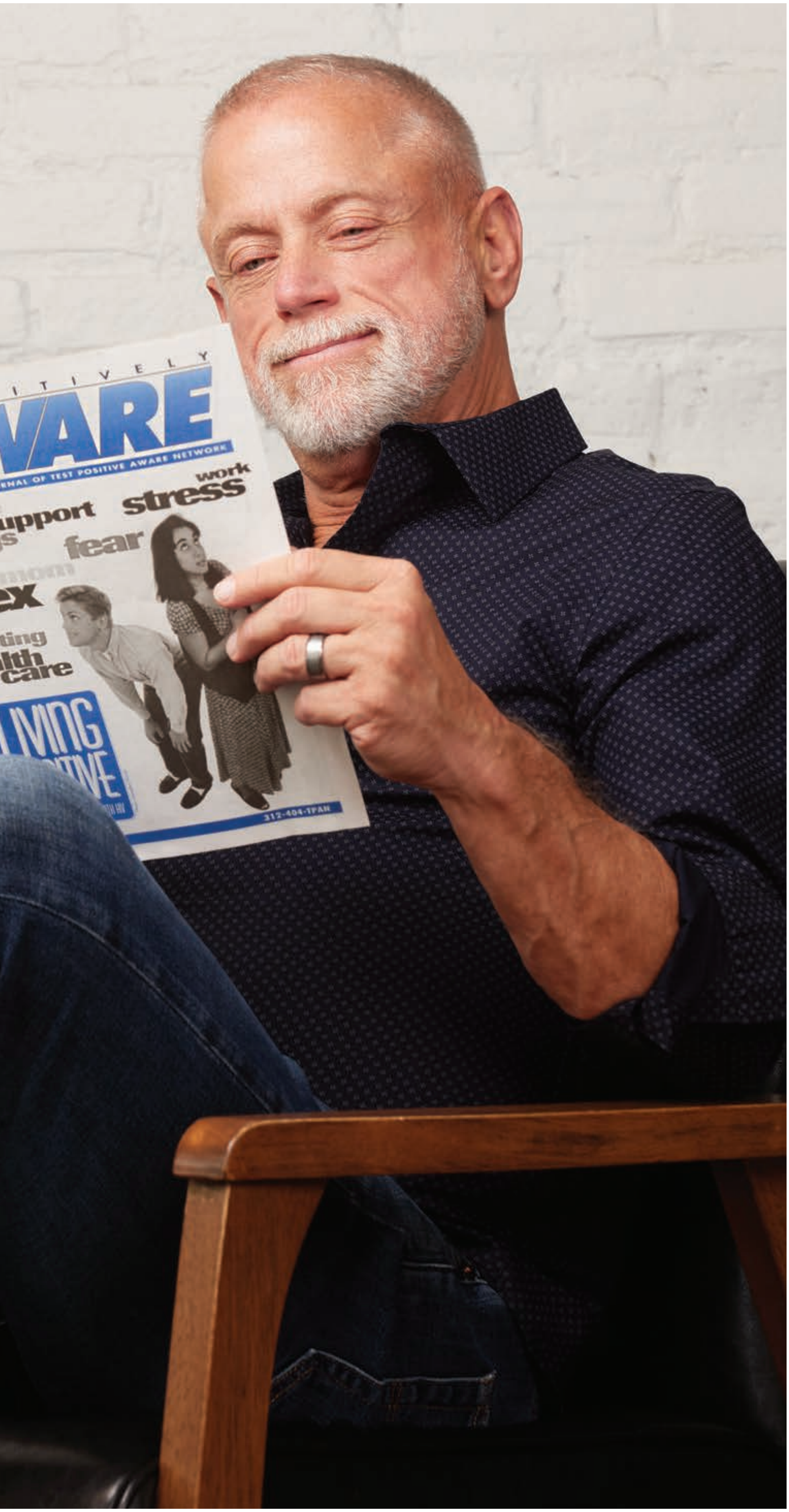
Dr. Shalit is Board Certified by the American Board of Internal Medicine and the American Academy of HIV Medicine, and is a Fellow of the American College of Physicians. He also serves as a Clinical Professor of Medicine at the University of Washington where he teaches about HIV treatment and prevention as well as general LGBTQ health.

READ about Dr. Shalit's earlier years in practice: thestranger.com/features/2015/09/09/22830406/inside-the-seattle-clinic-that-survived-the-darkest-days-of-aids.

ON TO THE NEXT CHAPTER

After 18 years, PA editor **Jeff Berry** sets his sights on new challenges

INTERVIEW BY **KARA EASTMAN**
PHOTOGRAPHY BY **JOHN GRESS**
STYLING BY **WILL MARTINEZ**



As the new CEO of TPAN—a social service organization serving people living with HIV—here only since August of 2021, I'm only beginning to unpack the longer history that TPAN has serving Chicago's diverse communities, and the people who have been involved for years are some of the most inspiring people I have ever met. One of the reasons the organization appealed to me was its signature publication, POSITIVELY AWARE *(PA). In my years of working in nonprofits I had never been involved in one that published its own magazine—I was intrigued. But now, after working with TPAN and PA for almost a year, I'm even more impressed and humbled by the reach that the magazine has. PA has readers all over the country—over 100,000 people, organizations, and clinics who rely on this bimonthly magazine. It also reaches an international audience through a growing digital presence. It is a beautiful publication that I was shocked to learn is created by an in-house editorial team of only three people. Keep in mind, when PA started, the people who were creating it were primarily gay men who either had HIV or had a partner with it, and many were dying. PA was saving lives by providing critical information and support. That legacy remains clear in the commitment and passion of Jeff Berry. He has been with TPAN for three decades and has served as editor-in-chief of PA for 18 years. He is the backbone of the magazine, and his dedication to his work is palpable. I am honored to have had the opportunity to work beside Jeff for the past year. When Jeff announced that he was leaving the organization, I, like many others around me, felt that we were witnessing the end of an era. But during our interview, he made me think that his time at PA was not his last chapter—there was a lot more to come from this giant in the field of HIV.*

KARA EASTMAN How did you get started at POSITIVELY AWARE?

JEFF BERRY I came to TPAN as a client. In 1989 I tested positive for HIV and did not know where to go. My doctor said he didn't have any patients with HIV, but that Northwestern had started an HIV clinic. In their waiting room, I saw the magazine on the table. It was there that I saw an ad for TPAN. I always like to say that when I came there it seemed like they had been around a long time, but in actuality it had only been around a couple of years. I was there during its infancy, starting out as a volunteer, and I have always worked in one capacity or another on the magazine. >>

How has the magazine changed?

It started out as a stapled mimeograph and became a local source of information. You have to remember, this was before the internet and people were dying. Whether it was print or a meeting—this was life or death. We would get many other newsletters from around the world because this is how we all got information. The magazine was always a vital source of information, and that has not changed—what has changed is how we access the information. After I started, TPAN and the magazine got a huge amount of funding to take the magazine national. It started as a monthly publication that did not have any advertising. We customized pages for each market nationally—Dallas had their four pages, Atlanta had theirs. First-wave cities [such as New York and San Francisco] had their own magazines, so we were trying to serve underserved communities. I can remember running down to the printer to get them the proofs (this was before computers). We have been intentional about focusing on prevention since many of our readers have partners who are not living with HIV. We have always covered disparities and inequalities, but we have grown even more intentional about making sure the magazine is a vehicle for racial and social justice. We lost a few readers when we started taking money from drug companies for advertising, but we have always made sure there is a firewall between advertisers and journalism. But what is most important is what is in the pages—content is king. We are also making sure our content is relevant and accurate and that the voices of people with HIV are heard.

What has kept you motivated to produce POSITIVELY AWARE?

I tell you, it's the personal stories we get from people who share them with us—stories of survival or a note of thanks for something they read that literally saved their life. Hearing from someone that if we hadn't printed that one story, they would not have known to tell their physician. It's also knowing that we're having an impact through a collaborative effort—PA is a team of people who are committed to excellence.

What keeps you up at night?

Funding is a huge issue. The thought that there is apathy and complacency, and people asking "is HIV still a thing?" The catch-22 is we have done so well to bring down transmission rates while also raising awareness and reducing stigma. Obviously, the work is not done, but we are competing with a lot of pandemics. It should not have to be that way—there should be enough resources for everyone.

> **'...it's the personal stories we get from people who share them with us—stories of survival or a note of thanks for something they read that literally saved their life. Hearing from someone that if we hadn't printed that one story, they would not have known to tell their physician.'**

Can you talk about some of the feedback you would get from readers?

There was a particular encounter that was meaningful to me. I was late to a conference and running to a session when this lovely woman recognized my face and said she wanted to thank me. She had been incarcerated and while there, had lost a friend to AIDS. She said the HIV drug guide gave her the ability and knowledge to talk to her physician while she was in prison. She is a trans woman who has just recently gotten her PhD and is doing amazing work. The fact that the magazine had any small part in that is more meaningful than if I had won the Mega Millions lottery last week. There is nothing like that.

Why is POSITIVELY AWARE important?

We are by the people, for the people. Many of our writers, contributors, and staff are people living with HIV. We carry those voices through to our readers; we try to represent all the voices of people who are otherwise voiceless. The commitment that we remain a conduit for people who are most marginalized is really key—and it comes from the heart. It's authentic.

Have you ever received negative feedback on a piece of writing?

No, that has never happened, Kara. [He laughs.]

What has been your favorite project?

Having the opportunity to have had a personal essay or editorial to document my journey with HIV over all the years. Also, interviews with Peter Staley, Alexandra Billings, David France, and even Tony Fauci. I was also able to do a Q&A with then-senator Barack Obama—through his staff, but still. I wrote a very personal piece about when I lost my mother to cancer. I remember going to an event here in Chicago, and so many people commenting on how much they liked the column. It never mentioned HIV; it was just about losing someone close to you and the importance of saying goodbye.

[This was a phone interview, so Jeff could not see my eyes tear up when he said that.]

What inspires you?

The people. The great work that is being done in the community. The younger generation's commitment to real change—they are the ones that are going to make it happen.

What kind of magazines do you like to read?

I like to read magazines that entertain me like *Vanity Fair* and inform me like *Consumer Reports*. We are kind of like the *Consumer Reports* of HIV.

What do you want to say to someone recently diagnosed HIV-positive?

You're gonna be okay. It's tough, I know. There are treatments now and you can live a normal life—near normal anyway. You don't have to do this alone.

What should we be doing to combat HIV?

There is a lot of work we need to do with addressing stigma. Getting the message of U=U out there. And a lot more help for people who do not have access to treatment.

What's next for Jeff Berry?

I'm taking some time off because I've never had a sabbatical—my bad. Then, I am going to be refocusing my efforts around HIV and aging. I'm not going anywhere—I am ready and excited to be working on another one of my passions. You're not done with me yet.

KARA EASTMAN is CEO of TPAN, the HIV/AIDS services organization that publishes POSITIVELY AWARE.

Global progress against HIV stalls

But many pockets of good news remain

BY **ENID VÁZQUEZ**

UNAIDS EXECUTIVE DIRECTOR **WINNIE BYANYIMA** SPEAKS AT THE OPENING SESSION

©STEVE FORREST/WORKERS' PHOTOS-IAS

The 24th International AIDS Conference (known as AIDS 2022) took place July 29–August 2 in Montreal and virtually, with several pre-conferences focusing on various special topics. As usual, the international conference brought some good and not-so-good news. Go to aids2022.org for tons of reports and photos.

Preventing STIs—the DoxyPEP study

"The DoxyPEP study found that taking 200 mg of doxycycline within 72 hours of condomless sex significantly reduces the risk of gonorrhea, chlamydia, and syphilis among men who have sex with men [MSM] and trans women," IAS reported in a press statement. "Among those randomized to take doxycycline, 65% fewer were diagnosed with an STI each quarter than those not taking doxycycline."

IAS called doxycycline "a game-changing tool to prevent sexually transmitted infections."

Amen to that.

More than 550 individuals in San Francisco and Seattle were in the study. All had a history of condomless sex with a male partner within the previous year. They had also had gonorrhea, early syphilis, or chlamydia within the previous year.

Two-thirds were given doxycycline PEP (post-exposure prophylaxis) to use following any condomless sex. The other third continued with the current standard of care. This control arm was stopped early when the PEP regimen showed efficacy. All study participants were then given doxycycline for PEP.

The 65% reduction amounted to an STI rate of 10.7% for the doxy folks vs. 31.9% for the non-doxy takers. So that's one person picking up an STI vs. one person plus two friends doing so.

Doxycycline is already provided for STI prevention at clinics around the country. Thank medical providers and community advocates. *Thank you. Gracias. Merci!*

The DoxyPEP trial was conducted at the HIV clinic at Zuckerberg San Francisco General Hospital and the San Francisco City Clinic, both part of the San Francisco Department of Public Health, and the Madison Clinic and the Sexual Health Clinic at Harborview Medical Center, both at the University of Washington. The study was funded by NIAID (the National Institute of Allergy and Infectious Diseases). Participants were either living with HIV or taking PrEP (pre-exposure prophylaxis) to prevent HIV.

Doxy may become some people's new best friend.

TAF shown superior to TDF for hepatitis B

For people living with both HIV and hepatitis B virus (HBV), there's an antiviral medication that treats both viruses and should be used in co-infection: tenofovir.

Tenofovir, however, is available in two forms. The ALLIANCE study is the first to compare the two medications in HIV/HBV co-infection. ALLIANCE found one version of tenofovir to be superior to the other for efficacy against hepatitis B.

"HIV/hepatitis B co-infection is a major global public health threat that increases morbidity and mortality beyond either infection alone," said Dr. Anchalee Avihingsanon, of the HIV-NAT (the HIV Netherlands Australia Thailand Research Collaboration) and the Thai Red Cross AIDS Research Center.

Although international treatment guidelines recommend a tenofovir-based HIV regimen for this co-infection, Dr. Avihingsanon said at a press conference, it is unknown which tenofovir drug is more effective against hepatitis B. "This is very important to me as a physician in Thailand," she said.

There were 243 participants without prior treatment history, from 11 different locations. Eighty-eight percent were Asian.

In Phase 3 results out to 48 weeks, tenofovir alafenamide (TAF) showed superiority for the treatment of hepatitis B. There was a 63% suppression of hepatitis B virus with TAF vs. a 43% suppression with tenofovir disoproxil fumarate (TDF). There was also superiority in HBV antigen seroconversion of 23% with TAF vs. 11% with TDF. The study is continuing to 96 weeks.

"The study is really exciting," said press conference moderator and IAS president

Sharon Lewin, an infectious disease physician and director of the Peter Doherty Institute for Infection and Immunity, in Melbourne. “**These findings have implications beyond HIV/HBV co-infection, but also for the many people living with hepatitis B alone.**”

As POSITIVELY AWARE hepatitis editor Andrew Reynolds reported in the hepatitis drug guide (July+August), hepatitis B is the most common infectious disease in the world. “In the United States, an estimated 850,000 to 2.2 million people live with HBV; about 10% of people living with HIV in the U.S. also have HBV,” Reynolds wrote. “In recent years there have been increases in HBV cases among people who inject drugs (PWID) and in mother-to-child (known as vertical) transmission in the U.S., directly related to the opioid crisis.”

TDF is sold under the brand name Viread. TAF for HBV comes under the brand name Vemlidy. Both medications are part of several single-tablet regimens for the treatment of HIV. ALLIANCE compared Biktarvy, which contains TAF, to a regimen of dolutegravir (brand name Tivicay) plus emtricitabine/TDF (brand name Truvada). Taking two pills instead of one Biktarvy may have given the TAF regimen an edge.

Both combo medications were equally effective against HIV, with more than 90% suppression of viral load.

Happy birthday to PrEP, but not happy equity

A research team including the CDC (Centers for Disease Control and Prevention) reported that, “PrEP was approved for HIV prevention in the U.S. in 2012; uptake has been slow. Black and Hispanic people have higher rates of new HIV diagnoses than White non-Hispanic people in the U.S.” The researchers advanced the idea of equity vs. equality for PrEP use.

“**Prevention programs should be guided by PrEP equity (use relative to epidemic impact), not PrEP equality (equal use in groups, regardless of HIV diagnosis proportion)**,” they reported.

Looking at pharmacy records for the first 10 years of PrEP, race/ethnicity data were found for 34% of PrEP users. The team made the assumption that the racial distribution was the same for the prescriptions without race information. They reported that the need for PrEP increased among all racial groups in all census areas examined for the decade.

The research group also came up with a PrEP-to-Need Ratio (PnR) as a measure for equity. They described the PrEP-to-Need Ratio as “the number of PrEP users in a group divided by the number of new diagnoses in that group in the same year.”

By this measure, they reported, “In all regions, PnR was highest for White and lowest for Black people.” The South had the lowest PnR rates of all regions. The racial and ethnic gaps only increased over time.

“Better programs are needed to provide PrEP to people at greatest risk for HIV infection,” the researchers noted in their conclusion.

Botswana achieves 95-95-95 goal

UNAIDS (the Joint United Nations Program on HIV/AIDS) has set the goal of 95-95-95: 95% of a country’s populace knows their HIV status; 95% of the persons diagnosed with HIV go on antiviral treatment; and 95% of the people on HIV treatment achieve undetectable viral load.

Botswana reported having not only achieved these targets, but has become one of the few countries in the world to surpass them. **The country, where one in five individuals is living with HIV, offers test-and-treat programs which immediately offers treatment to anyone diagnosed with HIV.** Moreover, HIV treatment is free.

...the need for PrEP increased among all racial groups in all census areas examined for the decade.

“In 2002, Botswana was the first African country to offer free HIV treatment to citizens,” the country’s Ministry of Health and Wellness reported. “Since then, Botswana has expanded treatment coverage and adopted evidence-based practices, including test-and-start and dolutegravir treatment.”

The findings come from a population-based survey that involved visiting thousands of households to offer HIV and viral load testing. This was the country’s fifth Botswana HIV/AIDS Impact Survey (BAIS V, 2021).

Although women as a group and the country’s population overall achieved 95-95-95, men only achieved the second two. They did, however, achieve more than 90% testing.

“Gaps remain in awareness among men 25–44 years and younger adults, particularly young women,” the report noted. Nevertheless, “Botswana has made tremendous progress in 20 years and is well-positioned to end the AIDS epidemic by 2030.”

Botswana shows the value of applying evidence-based practices.

UNAIDS report: Progress against HIV has reversed

For each international conference, UNAIDS reports on global progress in defeating HIV, or lack thereof. This year’s report, in a time of COVID, showed reverses.

“New data from UNAIDS on the global HIV response reveals that during the last two years of COVID-19 and other global crises, progress against the HIV pandemic has faltered, resources have shrunk, and millions of lives are at risk as a result,” the agency reported.

There was a drop in new transmissions of 3.6% between 2020 and 2021, the smallest decline seen since 2016. There were increases in new transmissions seen in Eastern Europe and central Asia, the Middle East and North Africa, and in Latin America. There were, however, “notable” declines in new HIV transmissions in western and central Africa and in the Caribbean. Still, UNAIDS noted, “even in these regions, the HIV response is threatened by a tightening resource crunch.”

“These data show the global AIDS response in severe danger,” said UNAIDS executive director Winnie Byanyima. “**If we are not making rapid progress then we are losing ground**, as the pandemic thrives amidst COVID-19, mass displacement, and other crises. Let us remember the millions of preventable deaths we are trying to stop.”

Instead, “Faltering progress meant approximately 1.5 million new infections occurred last year—over 1 million more than the global targets.”

There was an increased number of transmissions worldwide in women and girls: “The gendered HIV impact, particularly for young African women and girls, occurred amidst disruption of key HIV treatment and prevention services, millions of girls out of school due to pandemics, and spikes in teenage pregnancies and gender-based violence. In sub-Saharan Africa, adolescent girls and young women are three times as likely to acquire HIV as adolescent boys and young men,” UNAIDS reported.

Other groups greatly affected by the HIV epidemic had even greater rates of transmissions: “As of 2021, UNAIDS key populations data show MSM [men who have sex with men] have 28 times the risk of acquiring HIV compared to people of the same age and gender identity while people who inject drugs have 35 times the risk, sex workers 30 times the risk, and transgender women 14 times the risk.

"Racial inequalities are also exacerbating HIV risks," UNAIDS continued. "In the United Kingdom and United States of America, declines in new HIV diagnoses have been greater among white populations than among black people. In countries such as Australia, Canada, and the United States, HIV acquisition rates are higher in indigenous communities than in non-indigenous communities."

The number of people going on antiviral treatment slowed down during the year, and UNAIDS reported that three-quarters of all people living with HIV have access to therapy, but 10 million do not, and only about half (52%) of children living with HIV have access. Worse, that gap between adults and children is growing.

"These figures are about political will. Do we care about empowering and protecting our girls? Do we want to stop AIDS deaths among children? Do we put saving lives ahead of criminalization?" asked Ms. Byanyima. "We can end AIDS by 2030 as promised. But what it takes is courage."

READ the 400-page report, entitled *In Danger: The UNAIDS Global AIDS Update 2022*, at unaids.org.

UNAIDS launches new podcast

Apropos of IAS 2022, UNAIDS kicked off a new podcast, "Against the Odds." "This is a series of frank conversations with guests whose lives have been touched in many different ways by HIV. We find out about the challenges they've faced, and what inspires them to strive for what may seem impossible goals," UNAIDS announced. **GO TO** unaids.org/en/podcasts or wherever you get your podcasts.

Giving meaning to U=U

In any language, U=U is giving young people the vocabulary to empower themselves

BY **RICK GUASCO**

FRANCO LUCIANO BOVA, JESSICA MARJANE DURÁN FRANCO, AND SHARIFAH KYOMUKAMA NALUGO SHARE HOW THEY GAVE MEANING TO U=U IN THEIR LIVES.

VIA IAS

It is a scientific reality that has changed lives. A person living with HIV who has a viral load that is undetectable as a result of successful antiretroviral treatment cannot pass on the virus to a sexual partner. Undetectable equals untransmittable—put simply, U=U.

A panel of young activists from Latin America and Africa described how U=U gave new meaning to their lives, confronting stigma and educating their communities about HIV.

'The personal is political'

"I don't like the term *serodiscordant* because it puts the accent only on what happens in my blood and in my boyfriend's blood. The beauty of human relationships goes far beyond that," said Franco Luciano Bova, a 28-year-old PrEP activist from Buenos Aires, Argentina, addressing the session in English. "Language, in addition to signifying a barrier to access—like now, when I am speaking to you in a language that is very uncomfortable for me—can also create meaning which then makes identities possible, and gives many people the right to exist, the right to be named for who they are, for who I am."

Bova met his future boyfriend, Matias, five years ago on Facebook, where they chatted once. Matias later recognized him on the street, where they chatted again and he then asked Bova out on a date, and they have been together ever since. "Since I already knew that with an undetectable viral load, he could not transmit the virus to me, I was always able to fully enjoy him entirely," Bova said. "Nonetheless, since he was an HIV activist, my friends looked at him with suspicion and stigma because they were afraid for me."

That prompted Bova to take to Facebook and begin posting about U=U. His posts went, well, viral. Bova and Matias soon took their education efforts to the next level, creating a nonprofit organization, Asociación Ciclo Positivo, aimed at youth, health care providers, and local governments, providing information and resources. So far, Bova said, 14 local governments and 37 organizations have committed to their campaign.

"I tell you my story, our story, because I am convinced that the personal is political," he said.

"Latin America has among the highest levels of wealth inequality of any region," he added. "We want being undetectable to stop being a privilege."

Breaking the silence

"I am a survivor of discrimination and the Mexican healthcare system," said Jessica Marjane Durán Franco. "When they know that I am a trans woman, they stare at my body. They ask questions loaded with racist, transphobic, misogynistic, and condescending prejudice."

A law graduate of the Universidad Nacional Autónoma de México (the

National Autonomous University of Mexico), she has advocated for the human rights of trans folk at the United Nations in Geneva, Switzerland, and is the founder of Red de Juventudes Trans (Trans Youth Network) in Mexico City.

Franco said that transgender women often encounter delays in receiving antiretroviral treatment as a result of stigma from medical personnel at all levels.

"If you are a person who lives on the streets, if you are a person of color, if you have been incarcerated, if you are a migrant, living with a disability, or are a sex worker, hope is such a nice word. We don't want it to be taken from us," she said. "Empowerment means to resist, to live as defenders. We want to keep living as trans women, as non-binary, and as gender non-conforming persons. Know that raising our voices is breaking the silence and the status quo."

Discovering meaning

When 25-year-old Sharifah Kyomukama Nalugo, of the Joint Clinical Research Centre, based in the Ugandan capital of Kampala, was told as a child that she had been born with HIV, she didn't understand what that meant. She also didn't grasp the murmurings of the schoolchildren around her, and even of family members. In their picturesque community near Uganda's Lake Mutanda, her mother tried to shield her from the stigma, telling Nalugo that she loved her. So it was a shock when she finally realized what was being said about her. Nalugo became withdrawn.

"I started being alone because I did not want people to get HIV," she said. "That's what I thought: I'm keeping away from people; I'm keeping them safe. And that was my life, all alone."

Nalugo's relatives threw her and her mother out of the house they shared, fearful they would get HIV. Nalugo and her mother were homeless. But her life changed when she turned to dance, a lifelong hobby of hers, performing at schools in a group that used music to educate people about HIV.

When the lockdown of the COVID-19 pandemic hit, Nalugo switched to social media, posting videos of her dancing on TikTok, just as the social media platform was beginning to take off in Uganda. She also started sending videos to WhatsApp groups, giving hope to people living with HIV. The negative comments were far outweighed by messages of affirmation and appreciation from other young people who responded to Nalugo's uplifting dance videos.

"They look at it and they're like, 'because of you, Sharifah, I am where I am today.'" she said. "When I heard about the U=U message, it was hope for us as young people, as people living with HIV, to share that we have a chance in life."

FIND these organizations online: Asociación Ciclo Positivo, ciclopositivo.org. Red de Juventudes Trans, juventudestrans.org. The Joint Clinical Research Centre, jcrc.org.ug.

© JORDI RUIZ CIRERA AND MARCUS ROSE FOR IAS

CONFERENCE SCENE (CLOCKWISE FROM TOP LEFT): SEX WORKERS PROTEST AT THE CLOSING PLENARY. VOLUNTEER GREETS ATTENDEES. TEZ ANDERSON AT THE GLOBAL VILLAGE. PANELISTS AT THE GLOBAL VILLAGE. PROTEST SPEECH AT OPENING SESSION.

Combination strategy

This year's cure workshop aimed to integrate community activists, clinicians, and researchers

BY **KARINE DUBÉ, JEFF TAYLOR,** AND **MICHAEL LOUELLA**

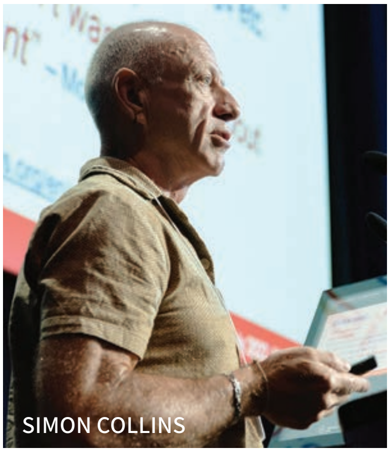
Held the day before the start of its AIDS 2022 conference, the International AIDS Society (IAS) hosted a hybrid workshop focusing on HIV cure research advances globally and research strategies under investigation while translating the latest science and incorporating diverse perspectives. Titled **Pathways to an HIV Cure: Research and Advocacy Priorities**, the meeting was organized in partnership with the Canadian HIV Cure Enterprise (CanCURE) and the Canadian AIDS Infectious Diseases Network. The 2022 IAS HIV cure workshop aimed for a full integration of community advocates, clinicians, biomedical researchers, and laboratory scientists.

A FEW HIGHLIGHTS

City of Hope patient: The City of Hope [cityofhope.org/hiv-patient-achieves-remission-following-stem-cell-transplant-city-of-hope], based in southern California, announced that a man diagnosed with HIV in 1988 had achieved potential cure following a stem cell transplant from a donor homozygous for the delta32 gene deletion. The stem cell transplant was administered in 2018 to treat acute myeloid leukemia (AML). The City of Hope patient stopped HIV treatment in March 2021 and has been off treatment for over 17 months. Following Timothy Ray Brown (the Berlin patient), Adam Castillejo (the London patient), the Düsseldorf patient, and the New York patient, this represents the *fifth* case of potential HIV cure following an intervention—although it was erroneously reported as the fourth case in the media. (See next page.)

Exceptional elite control of HIV: A woman in Barcelona was found to have achieved a state of "exceptional elite control" [aidsmap.com/news/aug-2022/barcelona-woman-controls-hiv-over-15-years-without-treatment] while she has remained off HIV treatment for over 15 years with undetectable HIV. The woman was treated early with antiretrovirals for nine months plus an immunosuppressive drug and does not have any genetic factors that would predispose her to achieving exceptional elite control. Her case adds to the scientific understanding of how people with HIV may be able to achieve a state of sustained HIV control.

Research priorities for an HIV cure: Dr. Sharon Lewin, professor of medicine at the University of Melbourne and now IAS president, presented the IAS Global Scientific Strategy towards an HIV cure, published in *Nature Medicine* [pubmed.ncbi.nlm.nih.gov/34848888] in late 2021. The strategy summarizes key scientific advances in the last five years, remaining knowledge gaps, and research priority areas for the next five years. The strategy focused on critical recommendations, including understanding and measuring HIV reservoirs (the main barrier to HIV cure), improving mechanisms of HIV control, developing effective interventions that target the provirus or the immune system, investing in cell and gene therapy, advancing pediatric remission and cure, and understanding the socio-behavioral, ethical, and community aspects of HIV cure research.


SIMON COLLINS

Simon Collins from i-Base in London, UK, gave the community keynote presentation on research priorities towards an HIV cure. Collins summarized key community asks around HIV cure research, including broadening engagement beyond existing advocates and community advisory boards, adopting inclusive research principles (e.g., women of all ages), expanding age criteria to include children and older adults over age 65, and using person-first and community-preferred language.

Tom Perrault, former HIV cure trial participant at the University of California San Francisco (UCSF), was interviewed by Michael Louella, Outreach Coordinator at the University of Washington (UW) Positive Research. Tom recounted his emotions throughout his entire HIV cure journey before, during, and after his HIV treatment interruption, and explained how he needed to mentally prepare to go back on antiretrovirals after the trial. Tom was grateful to researchers for having given him the opportunity to participate and to advance the search towards an HIV cure.

Increased emphasis on conducting HIV cure research in Africa: Krista Dong [researchers.mgh.harvard.edu/profile/914051/Krista-Dong] from Massachusetts General Hospital (MGH) described the Females Rising through Education, Support, and Health (FRESH) cohort, currently implementing a cure-related clinical trial in Durban, South Africa, sponsored by Gilead Sciences. Dr. Dong emphasized that scientists need to conduct HIV cure research in regions with the highest burden of HIV. She also stressed that embedding social and behavioral research is a critical imperative to strengthen the design of HIV cure research.

The cure workshop concluded with a panel describing efforts to expand HIV cure research efforts in Africa—including Dr. Cissy Kityo from the Ugandan Joint Clinical Research Center (JCRC) and Moses Supercharger, both of whom joined virtually after being denied a visa to travel to Canada. Jen Adair, who leads the Global Gene Therapy Initiative (GGTI) [pubmed.ncbi.nlm.nih.gov/34493840], described reasons why investing in cell and gene therapy for HIV cure research in low- and middle-income countries is a sound scientific investment.

FOR MORE INFORMATION
about the 2022 International AIDS Society (IAS) Towards an HIV Cure Workshop, go to: iasociety.org/events/pathways-hiv-cure-research-and-advocacy-priorities.

COLLINS: ©MARCUS ROSE/IAS

‘Hope’ blooms

Long-term survivor and activist **Matthew Sharp** reflects on news of the *fifth* adult to be cured of HIV—the aptly named ‘City of Hope patient’

The 24th International AIDS Conference completed a five-day in-person and virtual meeting from Montreal in July. Promising reports in several key areas of treatment, prevention, and in the search for a cure sparked an upbeat mood for conference goers. Despite challenging years with the global COVID epidemic, limited healthcare infrastructure and staffing, the changing political climate, and even the new monkeypox outbreak, there continue to be ongoing issues in HIV such as stigma, the growing number of people aging with HIV, and rollout of new prevention tools to everyone globally who needs them.

A REPORT ABOUT the City of Hope cure trial was presented by Jana Dickter of City of Hope at a press conference in Montreal. In 2018 the “City of Hope patient” received stem cells from donated HIV-resistant cells to treat leukemia. “A 66-year-old Caucasian man who received a stem cell transplant is the [fifth] known person to go into HIV remission. Diagnosed with HIV in 1988, he received chemotherapy and an allogeneic hematopoietic stem cell transplant after developing acute myelogenous leukaemia in 2018. Before that, he had an undetectable HIV-1 viral load on ART for many years.

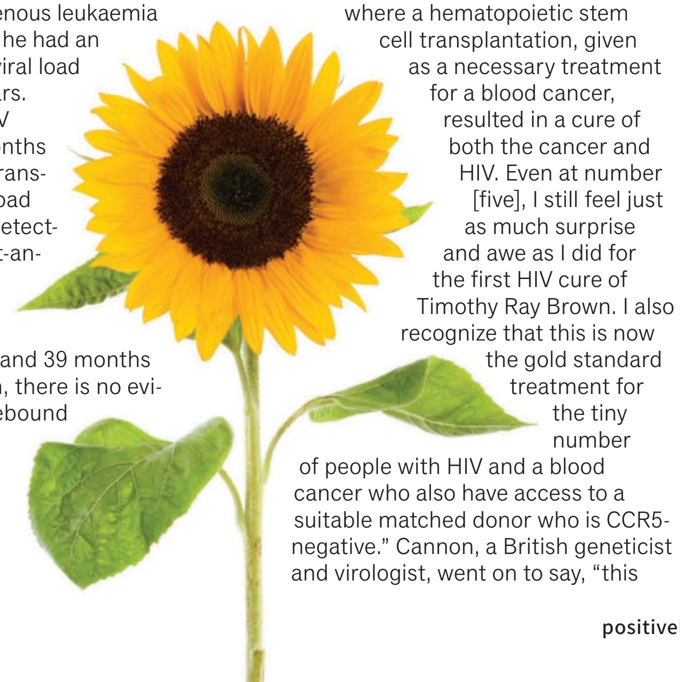
“He continued HIV treatment for 25 months after the stem cell transplant, and his viral load levels remained undetectable 12 months post-analytic treatment interruption. As of 14 months after stopping treatment and 39 months post-transplantation, there is no evidence of HIV RNA rebound and no detectable HIV DNA.

“Immunological studies 37 months after the stem cell transplant and 12 months post-analytic treatment interruption showed a robust response to cytomegalovirus stimulation and no response to HIV CD4 and CD8 T cells.”

I did not know about this trial until my cousin sent me a link to Mark Johnson’s story, “Longtime HIV patient is effectively cured after stem cell transplant,” in the *Washington Post* on July 27. I realized, however, that my involvement with cure research activism and participation had waned. There were so few successes and the research moved way too slowly for my taste. I didn’t get cured as the second patient to participate in a gene editing trial, even though I believe I got long-term clinical benefit. I realized I would most likely never really get completely cured of HIV and frankly lost interest, until the City of Hope trial.

Even at number [five], I still feel just as much surprise and awe as I did for the first HIV cure of Timothy Ray Brown. I also recognize that this is now the gold standard treatment for the tiny number of people with HIV and a blood cancer who also have access to a suitable matched donor who is CCR5-negative.

PAULA CANNON, a distinguished professor of molecular microbiology and immunology at the University of Southern California, and one of the most brilliant (and entreating) scientists I have ever known, put it this way, “This is now the [fifth] well-documented case where a hematopoietic stem cell transplantation, given as a necessary treatment for a blood cancer, resulted in a cure of both the cancer and HIV. Even at number [five], I still feel just as much surprise and awe as I did for the first HIV cure of Timothy Ray Brown. I also recognize that this is now the gold standard treatment for the tiny number of people with HIV and a blood cancer who also have access to a suitable matched donor who is CCR5-negative.” Cannon, a British geneticist and virologist, went on to say, “this will always remain a very niche treatment, but the lessons we are learning keep motivating scientists and clinicians as we try to derive parallel approaches that could be used in a much broader group of people. At the same time, advances in cell and gene therapy techniques, which are providing cures for diseases such as sickle cell disease, are also providing new platforms to attempt this. Altogether this makes me very optimistic for continued progress towards a broadly applicable HIV cure.”



ADAM SMIGIELSKI-ISTOCK

THIS RESEARCH COMES at an important moment when the long-term survivor movement is building confidence, mobilizing, gaining power and hope for a long life. And while a cure using this stem cell approach won’t be for everyone with HIV/AIDS, it provides some relief and hope that there is possibility! Those of us who are the oldest, having gone through 40+ years of the AIDS epidemic, COVID trauma, isolation, suicide, financial and housing insecurity, monkeypox trial and error, despair, loss, and stigma—we can’t give up hope for one small miracle, for a cure in some if not all of us! Some of us survivors might have the chance for a cure.

“This case is exciting because it’s the oldest bone marrow/stem cell transplant to date—proving that chronically infected long-term HIV survivors can successfully undergo this taxing procedure,” said Jeff Taylor, long-term survivor, HIV cure research activist, and community project leader at the HIV & Aging Research Project-Palm Springs. “Given that the majority of PLWH are now over 50—and that proportion will only go up—it’s important that we be conducting cure research in this population.”

BEING BRIDGETTE

BRIDGETTE PICOU

‘Just us’

Social justice needs a new framework

> ‘So much change in the world, with no progress.’

I find myself struggling to write these days. When I have time to sit and think, I feel like I’m going in a hundred directions at train wreck speed. Complete with that feeling you get as you watch the wreck about to happen, but can’t stop it. I’m struggling with social anxiety while trying to remain balanced and to not be scarred by resentment and anger at the sight of another unarmed black man killed.

Sometimes HIV is not my biggest problem. There are periods of time when I have my HIV and all its little subtleties well in hand. It’s the rest of the world’s influences and changes that mess me up. So much change in the world, with no progress. The sheer volume of change is crazy to think about, but the fact that there has been little to no progress is mind boggling.

George Floyd’s murder in the spring of 2020, the Black Lives Matter movement, and the protests that brought people of all backgrounds together, but led to no real police reform is an example. The recent Supreme Court rulings on abortion, the environment, and concealed carry laws are yet other examples of major changes in society. They are all rulings that will affect the world at large either through trickle down effects (environment and policing) or directly (Roe v. Wade), but are they progress? I argue not. We’re regressing. Where is justice and peace of mind? What basic rights to personal and individual autonomy will we lose next? It’s scary. Your opinion may differ on whether one or the other moves us forward or backward, but the fact remains that they will affect us all. Social identity and privilege will play a role in how you are impacted, as will where you live geographically and your own sense of your place in the world. Justice for one (or some) doesn’t translate into justice for all.

The black community has a saying when it comes to justice. *There is no justice, there is “just us.”* I first remember hearing it in a Richard Pryor joke, but black folks’ jokes are often rooted in a feeling of needing to deflect trauma with humor. “Just us” is a long-running sentiment—we feel like that because of systems in place that constantly test our worth as humans and shake up our place in the world. I think a whole new segment of people are feeling that shaking right now but I cannot feel good about it.

I, for one, am feeling the sway of the constant bombardment of negative information. Book banning, phobias about everything LGBTQ related, regular news about unarmed black men killed, black women coming up missing, attempts to call slavery and race issues anything but what they are: politics— it’s constantly rattling my idea of what common sense in society and sociology should be. For me, my social identity is not just my family and friends or my social activities and communities. It’s the overlap and interconnection of those things with my work/life balance. It’s the framework and services that support those things. That framework hasn’t been particularly fair, but at least it was there. Social justice needs a new framework. It needs new services to rebuild in a more balanced way. It needs “just us.” All of us.

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

PICOU: CHAD SAIN · PROTEST: GAYATRI MALHOTRA-UNSPLASH

FREE TIME

What hobbies and other activities do you enjoy?

We asked our social media followers to post their answers—and pictures

BY **RICK GUASCO**

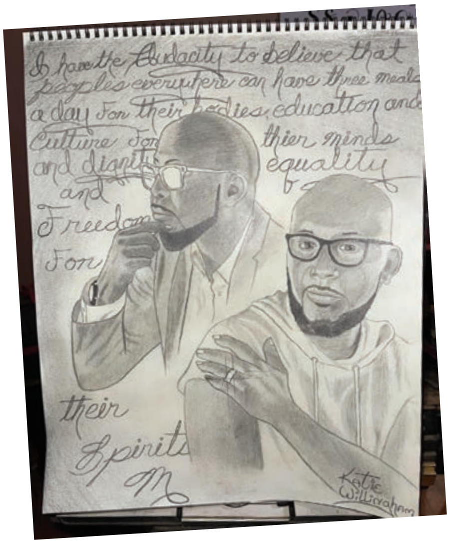
“Taking my dogs to the Minnehaha Dog Park in Minneapolis to decompress.”
—PATRICK ALI-INGRAM

“Smartphone photography, volunteering, fur babysitting.”
—ANTHONY JOHNSON

“My dogs. I have three, therefore walks and playing fetch can be a five-minute activity or over an hour.”
—XIO MORA-LOPEZ

“I enjoy reading.”
—JOHN CODY WALKER

“Self-care is important, so this is where I escape from the world. It’s never too late to learn something new and thanks to my meds I’ve got plenty of time to follow my dreams.”
—KATIE WILLINGHAM



“I knit and I do genealogy research.”
—MARK L GRANTHAM

“Reading. Arts and crafts. Volunteering. Social media.”
—CAMERON BRITTANY

“J’adore cuisiner et regarder le football.”
I love to cook and watch football.
—ISSEU DIALLO

“Coffee and sarcasm.”
—LARRY FRAMPTON

“Playing fetch with my 17-year-old Chinese Crested Powderpuff.”
—GEORGY MEDEIROS

“Woodworking.”
—TEO DRAKE

“Me gusta ir al gimnasia, por salud mental y física, hacer zumba y ahora mismo estoy aprendiendo a tocar piano.”
I like to go to the gym, for mental and physical health, do Zumba and right now I am learning to play the piano.
—@AZADFITSTYLE

“Singing with the New York City Gay Men’s Chorus!”
—BRUCE WARD

“Fishing. Roller skating. Bingo.”
—FRED SMITH

“This has become one of my favorite hobbies.”
—KALVIN PUGH

“Being a stay-at-home foster parent of three wonderful kids, three dogs, and five cats with a wonderful husband.”
—AYRICK BROIN-BURRIS

“Gospel music is something we enjoy, with me being a music major in college and both of us participating in the national GMWA [Gospel Music Workshop of America] workshops in the past. We are members of the local Houston and Texas chapter of the GMWA. Although we aren’t active anymore, we still keep up with the national GMWA conference every year and support the activities of the Houston and Texas chapter. We support the musicians, songwriters and singers as they release new music.”
—KALVIN AND EUNICE MARSHALL

“Cuddling with my lovely dogs.”
—SASCHA REX

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