

THE AMERICAN ACADEMY OF HIV MEDICINE ■ DECEMBER 2021

HIV

SPECIALIST



HIV & JUSTICE

Ending HIV Criminalization

HIV and Race in America

Omitting Sex Workers
from the NHAS

Molecular
HIV Surveillance



ACADEMY MENTORING PROGRAM

AMERICAN ACADEMY
OF HIV MEDICINE

THE ACADEMY MENTORING PROGRAM

matches seasoned, credentialed HIV care providers with practitioners seeking additional clinical support. Through one-on-one interactions, we can build the next generation of HIV care providers!

Mentoring benefits everyone. Mentees receive expert guidance from experienced HIV care providers. Mentors have the opportunity to pass on their accumulated knowledge and experience to a new generation of skilled practitioners. And patients receive a higher quality of care.

Enrollment for both mentees and mentors is now open!

You can find more information about the Academy Mentoring Program, at <https://community.aahivm.org/mentoring>.



CHAIR/BOARD OF DIRECTORS

Jonathan Appelbaum
MD, FACP, AAHIVS

EXECUTIVE DIRECTOR

Bruce J. Packett II

DIRECTOR OF MARKETING & COMMUNICATIONS

Amber McCracken

COPY EDITOR

Christy J. Adams, PA-C, MHS, AAHIVS

PUBLICATION DESIGN AND ART DIRECTION

BonoTom Studio, Inc.
703-276-0612, info@bonotom.com

ADVERTISING

Rob Glass
AAHIVM Advertising Sales
c/o The YGS Group
p: 717.430.2212 • c: 717-873-6491
robert.glass@theygsgroup.com

PUBLISHER



**AMERICAN ACADEMY OF
HIV MEDICINE**

**The American Academy
of HIV Medicine**

1705 DeSales St., NW, Suite 700
Washington, D.C. 20036
202-659-0699 • 202-659-0976
info@aaahivm.org • www.aaahivm.org

EDITORIAL ADVISORY GROUP

CHAIR

Milena Murray,
PharmD, MSc, BCIDP, AAHIVP

Associate Professor of Pharmacy Medicine
Midwestern University College of Pharmacy, Downers Grove Campus
HIV/AIDS Clinical Pharmacist, Northwestern Memorial
Chicago, Illinois

Joseph S. Cervia,
MD, MBA, FACP, FAAP, FIDSA, AAHIVS

Clinical Professor of Medicine and Pediatrics,
Donald and Barbara Zucker
School of Medicine at Hofstra/Northwell
Senior Medical Director,
HealthCare Partners, IPA & MSO
Garden City, NY

D. Trew Deckard, PA-C, MHS, AAHIVS

Steven M. Pounders, MD, PA
Dallas-Fort Worth, TX

Theresa Mack,
MD, MPH, FACP, AAHIVS
Mount Sinai Morningside Hospital
New York, NY

Richard C. Prokesch,
MD, FACP, FIDSA, AAHIVS
Infectious Diseases Associates,
Riverdale, GA

William R. Short, MD, MPH, AAHIVS
UPenn Perelman School of Medicine
Philadelphia, PA

FEATURES

8 Science, Not Stigma

It's Time to End HIV Criminalization

BY STEVEN R. BRYSON AND RONDA B. GOLDFEIN

10 You Care About HIV Criminalization

You Just Don't Know it Yet

BY COLEMAN GOODE

14 Demanding Better

An HIV Federal Policy Agenda by People Living with HIV

BY U.S. PEOPLE LIVING WITH HIV CAUCUS

16 HIV and Race in America

Making a Case for Equity and Racial Justice

BY LEONARD SOWAH, MBCHB, MPH, FACP

20 The Omission of Sex Workers from the Federal Response to the HIV Epidemic

BY: CHAUNCEY MCGLATHERY

24 Molecular HIV Surveillance

Two Sides of the Same Coin, One Path to Harm

BY KAMARIA LAFFREY AND ANDREW SPIELDENNER, PHD



DEPARTMENTS

2 LETTER FROM THE DIRECTOR

BY BRUCE J. PACKETT, EXECUTIVE DIRECTOR, AAHIVM

3 IN THE NEWS

Experimental Phase 2b HIV Vaccine Regimen Provides Insufficient Protection in Preventing HIV; Mortality Risk in Transgender People Twice as High as Cisgender People, Data Spanning Five Decades Suggests; New Report on COVID-19's Impact on PrEP, PEP and Sexual Healthcare; Impaired T cell Function Precedes Loss of Natural HIV Control

28 ON THE FRONTLINES

HIV Care Tools

A Pocket Resource for HIV Care Providers

BY: NICOLÉ MANDEL

30 MEMBER SPOTLIGHT

Jonathan S. Appelbaum, MD, FACP, AAHIVS, Tallahassee, FL

BY AARON AUSTIN

32 CLINICAL RESEARCH UPDATE

BY CAROLYN CHU, MD, MSC, AAHIVS



By BRUCE J. PACKETT II

Executive Director, AAHIVM

It's More than just Clinical

ON WORLD AIDS DAY (December 1) this month, the Biden Administration released its anticipated updates to the National HIV/AIDS Strategy (NHAS), underscoring the issues of stigma, inequities, disparities, workforce and system capacities, and long-term HIV outcomes with aging as key factors in an on-going epidemic. Those of us working in the HIV/AIDS advocacy community have been harping on these themes for years and years, as virtually everyone accepts that U most certainly equals U, and that what is stopping us from truly ending the epidemic are these social and economic determinants of health and health care access.

In just about every press release, media interview and statement made by the Academy on issues of HIV policy and care access we have uttered the seemingly bland phrase “we have the tools we need...”; and perhaps more importantly, beyond just stating what we have in the clinical toolbox, advocates and (some) policymakers have for some time now clearly identified the issues still in play, which have very little to do with the medical sciences themselves. And yet the epidemic contin-

ues on from year to year, right here in the “richest” country on earth.

Entirely appropriate, then, that this issue of the *HIV Specialist* chooses as its guiding through-line the concept of “justice” in HIV, with all of the writers herein making direct and precise connections between the contours of this concept and the eradication of the disease, as has the Administration itself in the latest iteration of the NHAS. Because I think what really needs to be taken away from this issue, and from the renewed federal efforts, is that “justice” isn’t just one issue among others in the HIV policy space, or just another issue in our magazine, but rather the north star that takes us where we need to go, and undergirds everything related to the disease, both inside the clinic and out. Specifically, we’re looking at: issues of ethnic and racial disparities (principally in an article authored by Chair of the Academy’s Council on Racial Equity (ACRE), Dr. Leonard Sowah); HIV criminalization laws and efforts to de-criminalize HIV; the issue of sex work and criminalization thereof, and how HIV prevention efforts should focus on this often underground industry; and emerging considerations around molecular surveillance of HIV.

Researchers, clinicians, policymakers and advocates all uniting hands and heartily proclaiming that Undetectable = Untransmittable several years ago should have immediately incited legislative processes to undo state laws all over the country, created during the ‘AIDS

hysteria’ of the early days, that effectively criminalized those with HIV doing what just about all humans desire to do, which is to have a normal, safe and enjoyable sex life. And yet the majority of states in the country continue to have some form of criminalization law on their respective books. This year we saw wins in some states like Illinois, to effectively strike these criminalizing, unjust and anachronistic laws, but a lot of work in this area still needs to be done. The net effect is further stigmatization of HIV, especially in the hardest-hit communities, often comprised by racial and ethnic minorities. All the pieces in this issue address specific sociological issues related to “justice,” but they are all deeply connected by each other.

Effectively, “we” have been asking providers of medical care to patients with and at risk for HIV to not only stay abreast of the clinical advances in order to serve their patients effectively, but also to become, essentially, advocates, sociologists, psychologists, health care navigators, payer/insurance experts, and cheerleaders for justice and fairness in their patients’ lives. It’s actually for this taxing and extraordinary reason that I wake up every day and work to support this passionate and beleaguered profession. As always, I thank you all.

A stylized, handwritten signature in black ink, appearing to read 'B. Packett'.

IN THE NEWS

NEW NATIONAL HIV/AIDS STRATEGY ADDRESSES SYSTEMIC BARRIERS TO ENDING THE EPIDEMIC

THE AMERICAN ACADEMY OF HIV MEDICINE commended the Biden Administration for releasing an updated National HIV/AIDS Strategy (NHAS), which renews the goal of ending the epidemic by 2030. President Biden unveiled the new plan on World AIDS Day, which offered the opportunity to commemorate those we have lost to HIV/AIDS, recognize the extraordinary clinical advances that have been made and thereby celebrate those with HIV who are living long, healthy lives.

The 2021 NHAS was released by the White House's Office of National AIDS Policy (ONAP), which was recently reopened after being closed by the previous administration and builds upon 2010 and 2015 plans. According to a statement provided by the Biden Administration, the 2021 NHAS has been updated to:

- Incorporate the latest data on HIV incidence, prevalence and trends;
- Expand the focus on addressing the social determinants of health that influence an individual's HIV risk or outcomes;
- Encourage reform of state HIV criminalization laws;
- Add a new focus on opportunities to engage the private sector in novel and important ways in the nation's work to end the epidemic.

According to the Academy, these are welcomed additions. Despite making tremendous progress over the past 40 years thanks to aggressive government initiatives and unprecedented scientific advances in HIV treatment and prevention, 34,800 new HIV infections occurred in the U.S. in 2019.

"Science can only take us so far," stated Academy Executive Director, Bruce J. Packett. "We have the clinical tools in our arsenal for HIV treatment and prevention. This new plan finally

begins to put a greater emphasis on the societal barriers that are perpetuating health disparities in our country. We will never be able to truly end the HIV epidemic until we look outside of the clinic doors. This updated National Strategy takes a big step forward by acknowledging systemic problems such as racism, stigma, health inequities and unjust HIV criminalization laws. We appreciate that the Biden Administration is not shying away from addressing these issues."

The Academy also applauds the NHAS' prioritization of growing the HIV care workforce. In 2020, the Academy surveyed its membership and found that 36 percent of respondents planned to retire by 2030. That same survey found that nearly 42 percent of respondents had experienced difficulties recruiting and hiring HIV clinical staff (MD, PA, NP, RN, Advanced Practice RN, Pharmacist) in the previous 12 months, with nearly 60 percent of respondents reporting having felt it more difficult to hire clinical staff than it was five years prior. Yet, 78.7 percent of respondents expected more providers would be needed for HIV-related care in their community over the next five years.

Legislatively, the Academy is actively supporting the bipartisan Bolstering Infectious Outbreaks (BIO) Preparedness Workforce Act (H.R. 5602), as well as the bipartisan HIV Epidemic Loan-Repayment Program (HELP) Act (H.R. 2295), which together will help build the next generation of HIV specialists, and infectious disease experts (including physicians, pharmacists, advanced practice providers, laboratory professionals, infection preventionists and dentists) to prepare for and respond to emerging health threats.

"We appreciate the continued focus on growing the HIV workforce, which is a core component to ending the epidemic," stated Packett. "Expanding the workforce both in number and in diversity will better address many of the issues related to access to prevention and care, health inequities and disparities.



IN THE NEWS

FDA Approves First Injectable Treatment for HIV Pre-Exposure Prevention

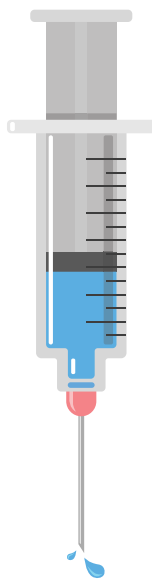
Drug Given Every Two Months Rather Than Daily Pill is Important Tool in Effort to End the HIV Epidemic

TODAY, the U.S. Food and Drug Administration approved Apretude (cabotegravir extended-release injectable suspension) for use in at-risk adults and adolescents weighing at least 35 kilograms (77 pounds) for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV. Apretude is given first as two initiation injections administered one month apart, and then every two months thereafter. Patients can either start their treatment with Apretude or take oral cabotegravir (Vocabria) for four weeks to assess how well they tolerate the drug.

“Today’s approval adds an important tool in the effort to end the HIV epidemic by providing the first option to prevent HIV that does not involve taking a daily pill,” said Debra Birnkrant, M.D., director of the Division of Antivirals in the FDA’s Center for Drug Evaluation and Research. “This injection, given every two months, will be critical to addressing the HIV epidemic in the U.S., including helping high-risk individuals and certain groups where adherence to daily medication has been a major challenge or not a realistic option.”

According to the U.S. Centers for Disease Control and Prevention, notable gains have been made in increasing PrEP use for HIV prevention in the U.S. and preliminary data show that in 2020, about 25 percent of the 1.2 million people for whom PrEP is recommended were prescribed it, compared to only about 3 percent in 2015. However, there remains significant room for improvement. PrEP requires high levels of adherence to be effective and certain high-risk individuals and groups, such as young men who have sex with men, are less likely to adhere to daily medication. Other interpersonal factors, such as substance use disorders, depression, poverty and efforts to conceal medication also can impact adherence. It is hoped that the availability of a long-acting injectable PrEP option will increase PrEP uptake and adherence in these groups.

The safety and efficacy of Apretude to reduce the risk of acquiring HIV were evaluated in two randomized, double-blind trials that compared Apretude to Truvada, a once daily oral medication for HIV PrEP. Trial 1 included HIV-uninfected men and transgender women who have sex with men and have high-risk behavior for HIV infection. Trial 2 included uninfected cisgender women at risk of acquiring HIV.



Participants who took Apretude started the trial with cabotegravir (oral, 30 mg tablet) and a placebo daily for up to five weeks, followed by Apretude 600mg injection at months one and two, then every two months thereafter and a daily placebo tablet.

Participants who took Truvada started the trial taking oral Truvada and placebo daily for up to five weeks, followed by oral Truvada daily and placebo intramuscular injection at months one and two and every two months thereafter.

In Trial 1, 4,566 cisgender men and transgender women who have sex with men received either Apretude or Truvada. The trial measured the rate of HIV infections among trial participants taking daily cabotegravir followed by Apretude injections every two months compared to daily oral Truvada. The trial showed participants who took Apretude had 69 percent less risk of getting infected with HIV when compared to participants who took Truvada.

In Trial 2, 3,224 cisgender women received either Apretude or Truvada. The trial measured the rate of HIV infections in participants who took oral cabotegravir and injections of Apretude compared to those who took Truvada orally. The trial showed participants who took Apretude had 90 percent less risk of getting infected with HIV when compared to participants who took Truvada.

Side effects occurring more frequently in participants who received Apretude compared to participants who received Truvada in either trial include injection site reactions, headache, pyrexia (fever), fatigue, back pain, myalgia and rash.

Apretude includes a boxed warning to not use the drug unless a negative HIV test is confirmed. It must only be prescribed to individuals confirmed to be HIV-negative immediately prior to starting the drug and before each injection to reduce the risk of developing drug resistance. Drug-resistant HIV variants have been identified in people with undiagnosed HIV when they use Apretude for HIV PrEP. Individuals who become infected with HIV while receiving Apretude for PrEP must transition to a complete HIV treatment regimen. The drug labeling also includes warnings and precautions regarding hypersensitivity reactions, hepatotoxicity (liver damage) and depressive disorders.

Apretude was granted a Priority Review and Breakthrough Therapy designation. The FDA granted the approval of Apretude to ViiV.

Landmark COVID-19 vaccine trial in sub-Saharan Africa is the first to study the efficacy of mRNA COVID-19 vaccines in people living with HIV

Ubuntu study is also the first to evaluate mRNA vaccine against the omicron variant

A HIGHLY ANTICIPATED clinical trial in eight sub-Saharan countries is the first to specifically evaluate the efficacy of a COVID-19 vaccine in people living with HIV, including those with poorly controlled infections. It also is the first study to evaluate the efficacy of vaccines—in this case, Moderna mRNA-1273—against the omicron variant of SARS-CoV-2, the virus that causes COVID-19.

In addition to examining the efficacy of COVID-19 mRNA vaccines in people living with HIV, the study investigators seek to identify the optimal regimen for this population and how it might vary based on whether an individual has previously had COVID-19 or not.

The trial will be conducted in East and Southern Africa—regions of the world that have been highly impacted by HIV. It is expected to enroll about 14,000 volunteers at 54 clinical research sites in South Africa, Botswana, Zimbabwe, Eswatini, Malawi, Zambia, Uganda and Kenya, where adult HIV prevalence ranges from 4.5 percent to 27 percent.

The study name, Ubuntu, borrows the Nguni word meaning ‘I am because you are,’ and embraces the concept of African coexistence and community. It refers to the interconnectedness of African nations and their collaborative efforts to combat HIV and COVID-19 in this region of the continent.

“Sub-Saharan Africa has been hit hard by the COVID-19 pandemic, but access to effective vaccines, especially mRNA technology, has been very limited,” said Dr. Nigel Garrett, co-chair of the study and head of Vaccine and HIV Pathogenesis Research at the Center for the AIDS Program of Research in South Africa (CAPRISA). “The Ubuntu trial will provide safety data to regulators and assess correlates of protection from COVID-19, and it will answer important questions on mRNA vaccine dosage regimens among people living with HIV.”

To find these and other answers, the study is expected to enroll about 12,600 people

living with HIV and about 1,400 who are HIV-negative. About 5,000 of the volunteers will have previously had COVID-19, confirmed by an antibody blood test done at initial enrollment. All participants will receive the Moderna vaccine, but dosages and schedules will vary depending on previous SARS-CoV-2 infection. Organizers said study participants living with HIV will receive access to optimal HIV treatment throughout the course of the trial.

“This region faces a huge HIV burden,” said Dr. Glenda Gray, Ubuntu study protocol lead adviser and president of the South African Medical Research Council (SAMRC). “Although safe and effective vaccines have been developed for COVID-19, HIV and COVID-19 are on a collision course,” she added. “The impact of COVID-19 on people living with HIV is a concern for the continent, particularly in light of the recently-sequenced omicron variant set to drive South Africa’s fourth wave and further infections globally.”

Dr. Philip Kotzé, one of the lead study investigators, said the Ubuntu study would not be possible without the crucial participation of rural communities across Southern and East Africa. “These communities have been disproportionately impacted by the twin pandemics of HIV and COVID-19, and they now have an unprecedented opportunity

to help advance science and improve our understanding of the immune response to SARS-CoV-2 in the context of HIV.”

Dr. Larry Corey, principal investigator of both the HIV Vaccine Trials Network (HVTN) and the COVID-19 Prevention Network (CoVPN), and co-leader of the network’s vaccine testing pipeline, said there currently are no U.S. government-sponsored studies of COVID-19 vaccines that quantitate vaccine efficacy among a diverse population of people infected with HIV. This study seeks to address this knowledge gap and establish whether mRNA vaccines are as effective in people living with HIV, particularly those with advanced disease, as they are in those who are HIV-negative.

The trial is sponsored by the SAMRC and funded by the U.S. government and supported by the National Institute of Allergy and Infectious Diseases (NIAID) within the National Institutes of Health. Funding originates from the Department of Health and Human Services (HHS) through the Countermeasures Acceleration Group (CAG).

“Vaccination and treatment are critical for those who face the dual threat of HIV and COVID-19, as they remain at high risk of acquisition and transmission and potentially can be the origin of future variants,” Corey said. “It is imperative that we as scientists and as society double-down on global efforts to find and make available effective vaccines and treatments. This study represents an important step forward in our efforts to reduce the burden of COVID-19 among HIV-infected persons and understand whether current dosage regimens are adequate.”

The Ubuntu study is led by the NIH’s CoVPN and modeled on extensive community engagement protocols pioneered and successfully implemented by the CoVPN and its research partner, the HVTN. Both networks are headquartered at the Fred Hutchinson Cancer Research Center in Seattle, Washington.



IN THE NEWS

People with HIV are at increased risk for heart failure

Kaiser Permanente research finds risk difference more pronounced in women, Asians and Pacific Islanders, and people under 40

PEOPLE WITH HIV are at higher risk of developing heart failure than people without HIV, a new study found.

The research, published December 13 in *Mayo Clinic Proceedings*, is one of the largest studies to investigate heart failure risk in people with HIV and how that risk varies by age, gender, race, and ethnicity.

“Cardiovascular disease has been an important concern for people with HIV for many, many years,” said the study’s senior author Michael J. Silverberg, PhD, MPH, a research scientist and HIV epidemiologist at the Kaiser Permanente Division of Research. “Most of the research in this area has focused on the risk of stroke and heart attacks. With this study, we now see the cardiovascular impacts for people with HIV extend to end-stage conditions such as heart failure.”

Silverberg and his colleagues identified 38,868 people with HIV who were Kaiser Permanente members between 2000 and 2016 in one of three regions: Northern California, Southern California, and the Mid-Atlantic States. Next, they matched each person with up to 10 Kaiser Permanente members from the corresponding region who were the same age, gender, and race but did not have HIV; this group included 386,586 people. Lastly, they identified the people in both groups who had developed heart failure during follow-up.

The study found that people with HIV were 68 percent more likely to develop heart failure than people who did not have HIV, and people who were age 40 or younger, female, or of Asian or Pacific Islander ethnicity were at the highest risk.

“In terms of young people, it’s possible that they had fewer other complicating health issues, which made heart failure stand out,” said the study’s first author Alan S. Go, MD, a senior research scientist at the Division of Research. “In women, preliminary data suggest HIV may have a greater impact on their cardiac function than it does in men, due in part to hormonal regulation and enhanced myocardial fibrosis, but that needs to be investigated



further. And, overall, not a lot is known about cardiac issues and HIV among Asians and Pacific Islanders.”

The analyses accounted for whether a person had risk factors for heart disease or was on medications to prevent heart problems. “Our study showed that the higher risk wasn’t due to differences in access to care,” said Dr. Go. “They were all getting the highest-quality care.” The study also showed that the higher heart failure risk was not because people with HIV had more risk factors for heart disease or just experienced more heart attacks. In fact, there was a higher prevalence of risk factors for cardiovascular disease among those without HIV, Dr. Go said.

The researchers said their study highlights why it is important for people with HIV and their health care providers to be aware that shortness of breath, fatigue, leg swelling, coughing, and chest pain can be signs of early heart failure. “HIV patients often receive all of their care in busy HIV primary care clinics, and it is possible that signs and symptoms of heart failure may be missed, resulting in delays in treatment,” said Silverberg.

Kaiser Permanente has been at the forefront of addressing heart disease in people with HIV. “An early study from Kaiser Permanente Northern California was among the first to show that people with HIV are at higher risk for cardiovascular disease,” Silverberg said. “So, we’ve been aware of the heart problems in this setting for a long time, and our patients have received excellent preventive care. Despite that, we are still seeing a higher risk of heart failure, and we need more research to understand why so we can intervene earlier.”

This study was funded by the National Heart, Lung, and Blood Institute of the National Institutes of Health.

CDC Updates Guidelines: Doctors Should Talk to All Sexually Active People About HIV PrEP

THE CDC updated its HIV PrEP guidelines, including a recommendation that doctors talk to all sexually active adults about HIV prevention and prescribe PrEP to anyone who asks for it.

On Wednesday, the US Centers for Disease Control and Prevention (CDC) updated its pre-exposure prophylaxis (PrEP) guidelines. The CDC is recommending doctors talk to all sexually active people about HIV prevention and prescribe PrEP to any patient who asks for it.

The updated guidelines reflect attempts to end the stigma surrounding HIV and HIV preventative measures, like PrEP. According to Demetre Daskalakis, MD, director of the CDC's Division of HIV Prevention, "Stigma is our biggest enemy... I really think this puts PrEP in

the same place as so many other really good preventive interventions like talking about smoking, alcohol, drugs, etc."

Though HIV PrEP is primarily marketed to men who have sex with men, a recent study found heterosexual sex accounts for 23 percent of new HIV diagnoses each year.

The CDC's updated guidelines recommend PrEP for persons who have a sexual partner with HIV, who have sex but do not consistently use a condom, or who have been diagnosed with a sexually transmitted infection (STI).

In their summary of the updates, the CDC noted the US Food and Drug Administration (FDA) is likely to approve the first long-acting injectable PrEP, cabotegravir, "within 2-3 months after the publication of this guideline."

In light of this anticipated approval,

the CDC recommended that PrEP with intramuscular cabotegravir injections is recommended for HIV prevention in adults who report sexual behaviors placing them at significant risk of HIV exposure and infection.

Another new inclusion in the guidelines outlined options for PrEP initiation and follow-up via telehealth, a reflection of how COVID-19 has changed healthcare.

The updated guidelines described procedures for prescribing and providing PrEP on the same day as the initial evaluation for its use ("same-day PrEP"). Allowing this quick turnaround emphasizes the CDC's commitment to PrEP uptake, virological suppression, and ending the HIV epidemic.

This article is reprinted from ContagionLive and was penned by Nina Cosdon

ACTG announces initiation of A5355, clinical trial studying new CMV vaccine

THE AIDS CLINICAL TRIALS GROUP (ACTG), the largest global HIV research network, announced the launch of A5355, a clinical trial studying a new cytomegalovirus (CMV) vaccine in adults with both HIV and CMV. The study will evaluate whether the new vaccine Triplex is safe and effective in eliciting a CMV-specific immune response in people living with HIV and is thus able to suppress CMV replication.

Almost everyone living with HIV is also living with CMV. There is strong evidence that living with both HIV and CMV is associated with chronic inflammation, which may be related to significant co-morbidities, including heart disease, strokes, neurological problems, and diabetes. Triplex is a modified vaccinia ankara (MVA)-based vaccine that encodes three full-length CMV antigens [pp65 (UL83), IE1-exon4 (UL123), and IE2-exon5 (UL122)]. Phase 1 and 2 studies conducted in more than 100 adults with hematologic stem cell transplants have demonstrated that Triplex is safe and can prevent CMV-related disease.

"Because almost all individuals living with HIV have also been exposed to CMV and they both persist across the lifetime, CMV is an important research focus as we seek to curtail the impact of other chronic diseases associated with HIV," said ACTG chair Judith Currier, M.D., M.Sc., University of California, Los Angeles. "The ACTG is eager to gain insights from this first-of-its-kind study into Triplex's potential ability to reduce systemic inflammation among people living with HIV, which can be linked to a number of health issues that impact their quality of life."

A5355 is a phase 2, double-blind, randomized, placebo-controlled study evaluating the safety and immunogenicity of two injections of Triplex in adults aged 18 to 65 living with both HIV and CMV. Participants will be randomized in a 2:1 ratio, such that 60 will receive Triplex and 30 will receive placebo at study entry (day zero) and week four, both through two intramuscular deltoid injections. Participants will be followed for 92 weeks after the last scheduled vaccination at week four, for a total study duration of 96 weeks. At least

25 percent of participants will be cisgender or transgender women, and all must have undetectable HIV RNA on antiretroviral therapy (with current CD4+ cell count >250 cells/μL and nadir CD4+ cell count ≥100 cells/μL).

"We hope that improved control of asymptomatic CMV replication will decrease systemic markers of inflammation and eventually improve the lives of people with HIV worldwide," said protocol chair Sara Gianella, M.D., University of California, San Diego (UCSD). "We are particularly excited that this study is making a dedicated effort to enroll cisgender and transgender women, who tend to be underrepresented in most HIV treatment studies."

A5355 is led by Dr. Gianella and Davey Smith, M.D., USCD. City of Hope, a National Cancer Institute-designated comprehensive cancer center in southern California, developed Triplex. It is being supplied to study A5355 by City of Hope and Don Diamond, Ph.D., a City of Hope professor. Helocyte, Inc., a partner company of Fortress Biotech, Inc, is the exclusive worldwide licensee of Triplex.

AROUND THE WORLD, the call is loud and clear to overhaul criminal justice systems that target and punish people for who they are. But any movement to stop targeting people based on race, gender, sexual orientation, or identity must also include an end to criminal punishment for activity by people with HIV (PWH) that would not otherwise be a crime.

Forty years ago, HIV hysteria ran rampant, and stigma rooted in ignorance, fear and hate prevailed. People were terrified of getting HIV, and instead of turning to public health education to learn about HIV transmission, they relied on the federal government for protection. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act signed into law by President George H.W. Bush¹ required states to have a legal mechanism to prosecute individuals *intentionally* spreading the virus. To receive funds to address the epidemic, states were required to enact laws targeting PWH.

In 2010, the CARE Act was recertified and the provision regarding HIV-related prosecution was removed. Despite this change in federal policy and advances in science and research that now enable PWH to live long, healthy, productive lives, the laws punishing them have remained. Thanks to advancements in antiretroviral (ARV) treatments, PWH who have an undetectable viral load cannot transfer the virus. But those with an undetectable viral load or who have otherwise mitigated the risk of transmission still face possible criminal punishment for consensual sexual activity because of outdated laws. The persistent fear of prosecution and resulting collateral damages is inescapable.

As some progressive states focus on criminal justice reform, advocates around the country struggle to modernize or eradicate laws targeting PWH. Roughly 31 states have HIV-specific laws or sentence enhancements for PWH to date.

The Model Penal Code is a set of criminal law principles and guidelines. The objective of criminal law should be “to give fair warning of the nature of the conduct declared to constitute an offense” and “to promote the correction and rehabilitation of offenders.”²

SCIENCE, NOT STIGMA

It's time to end HIV criminalization

By Steven R. Bryson and
Ronda B. Goldfein



Punishing PWH who don't present a risk to others is based on HIV-related stigma, not the objectives of criminal law. Historically, HIV-specific statutes infer intent based solely on an individual's knowledge of their HIV-positive status, instead of requiring a prosecutor to establish that the defendant intended to infect their partner or recklessly ignored the risk of transmission.³ Idaho's HIV-specific statute entitled "**Transfer of body fluid which may contain the HIV virus—Punishment—Definitions—Defenses**" is a perfect example.

(1) Any person who exposes another in any manner **with the intent to infect OR, knowing that he or she is or has been afflicted with acquired immunodeficiency syndrome (AIDS), AIDS-related complexes (ARC), or other manifestations of human immunodeficiency virus (HIV) infection**, transfers or attempts to transfer any of his or her body fluid, body tissue or organs to another person is guilty of a felony and shall be punished by imprisonment in the state prison for a period not to exceed fifteen (15) years, by fine not in excess of five thousand dollars (\$5,000), or by both such imprisonment and fine. Idaho Code Ann. § 39-608 (West) (emphasis added).

This problematic statute uses people's knowledge of their HIV status against them. Most laws targeting PWH do not consider the actual risk of transmission or transmission. These statutes also ignore medical advancements.

Some HIV criminalization laws target PWH for prosecution for nonsexual conduct, such as spitting, which never poses a risk of exposure to the virus. Laws that do not consider the actual risk of exposure to the virus criminalize the person, not the conduct. When the focus of the law is to target sexual conduct, rather than the risk of transmission, the message is "that sexual contact with a person living with HIV is in itself harmful, regardless of the risk of transmission."⁴ Statutes that perpetuate stigma diminish the self-worth of PWH.

The Centers for Disease Control and Prevention's (CDC) initiative, *Ending the HIV Epidemic (EHE)* identifies HIV-related stigma as a contributing barrier to a successful HIV response.⁵ The EHE acknowledges many contributing root causes which lead to disparities in approach to ending the epidemic, such as poverty, unequal access to healthcare, limited education and employment opportunities, stigma, and systemic racism and homophobia, and working to implement policies, practices, and programs that help to overcome these obstacles. Despite that acknowledgment, the CDC has issued little to no guidance surrounding repeal or reform of HIV-specific laws.

In the spring of 2021, the United Nations Development Programme released *Guidance for Prosecutors on HIV-related Criminal Cases*. The guidance notes that HIV criminalization is not an effective HIV prevention policy.⁶ Furthermore, there is little or no evidence that the criminalization of HIV helps to prevent new infections to any significant degree by deterring sexual risk behaviors or

encouraging disclosure. The guidance continues to instruct prosecutors worldwide to use prosecution of HIV-related offenses as a last resort given the gravity and consequences of criminal prosecution.

The U.S. People Living with HIV Caucus outlined their policy agenda, *Demanding Better: An HIV Federal Policy Agenda by People Living with HIV*, for the federal response to the HIV epidemic. Their recommendations are outlined in an article in this magazine's cover package.

Historically, the federal government's response to the HIV epidemic has been too little too late. It's time for the federal government to issue guidance to states surrounding HIV-related prosecutions. Most existing statutes were enacted as a result of the federal legislation. The federal government must now work to reform the outdated statutes it created.

To end an epidemic, we need to embrace science, not stigma. **HIV**



STEVEN BRYSON is the first Sero Project Fellow at the AIDS Law Project of Pennsylvania. His primary work focuses on policy reform combating the criminalization of HIV and criminal defense. Prior to joining the AIDS Law Project, Steven was an assistant district attorney and assistant city solicitor of Philadelphia. He's a graduate of Temple University and University of Baltimore School of Law with honors.



RONDA B. GOLDFEIN is in her 21st year as executive director of the AIDS Law Project of Pennsylvania, the nation's only independent public-interest law firm providing free legal services to people living with HIV. She is co-founder and vice president of Safehouse, a public health approach to overdose prevention that seeks to open a supervised injection site in Philadelphia. She is a longtime member of the ACLU's Philadelphia chapter board of directors.

REFERENCES

1. <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/ryan-white-hiv-aids-program-legislation>
2. <https://www.britannica.com/topic/criminal-law>
3. Margo Kaplan, Rethinking HIV-Exposure Crimes, 87 Ind. L.J. 1517, 1532 (2012)
4. Ibid at 1517, 1535
5. What Is Ending the HIV Epidemic in the U.S.?, HIV.gov (June 2, 2021), <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>.
6. UNDP Guidance for Prosecutors on HIV-related Criminal Cases



You Care About HIV Criminalization

WHEN I WAS 29, I experienced someone trying to blackmail me into going on a date with him. He threatened to go to the police and accuse me of lying about my HIV status to have sex with him. I have a sign in my cubicle that states, “You Care About HIV Criminalization You Just Don’t Know It Yet!” Those words are true for everyone living with HIV in states where HIV-specific laws are on the books.

The term “HIV Criminalization” refers to the criminal prosecution of people with HIV/AIDS, including non-disclosure of their HIV status, potential or perceived HIV exposure or HIV transmission. People with HIV (PWH) have been stigmatized since the very start of the epidemic because of fear. When the HIV epidemic was in its early stages, many states implemented these HIV-specific criminal exposure laws to discourage behaviors that could lead to transmission of HIV (including but not limited to biting, spitting, and throwing feces). In 1990, the Ryan White Comprehensive AIDS Resources Emergency Act (CARE), which provides funding to states for AIDS treatment and care, required states to certify that criminal laws were adequate to prosecute individuals who knowingly exposed another person to HIV.¹

As of the beginning of 2021, 28 states, including Illinois, had laws that criminalize PWH who engage in sexual activities without notifying their sexual partners of their HIV status or who cannot provide proof of such notification. These laws vary as to what behaviors are criminalized.² Several states also criminalize one or more behaviors. Illinois modernized its law in 2012 to narrow the situations that can result in prosecution for criminal transmission.³ Until recently, PWH could be charged under the 720 ILL. COMP. STAT. 5/12-5.01 in Illinois for engaging in condomless anal or vaginal sexual intercourse without first disclosing their HIV status to their partners. It was a Class 2 felony, punishable by three to seven years in prison and a \$25,000 fine, for PWH who knew their HIV status to engage in “sexual activity” with another person without using a condom. The definition of “sexual activity” was limited to insertive vaginal and anal intercourse.



By: Coleman Goode

**You just
don't know
it yet**

YOU CARE ABOUT HIV CRIMINALIZATION: YOU JUST DON'T IT YET

In the last nine years, the movement to end the criminalization of PWH in Illinois picked up steam that culminated in the full repeal of the law during the spring legislative session and later signed into law on July 27, 2021.⁴ But let's go back and talk about why these laws cause so much harm to the communities they are supposed to be protecting.

We are 40 years into the HIV epidemic and these laws have only contributed to keeping the epidemic going because of the stigmatizing language that describes PWH as "dangerous." Black and Brown communities have been disproportionately targeted and impacted by mass incarceration since the early 1980's. According to the Center for Diseases Control and Prevention (CDC), HIV disproportionately affects Black communities at a higher rate than that of their White counterparts. The rate of new HIV diagnoses per 100,000 among Black adults/adolescents at 47.5 percent was eight times that of Whites 5.6 percent and more than twice that of Latinos 20.9 percent in 2018. Black men at 74.8 percent were the highest of any group, twice that of Latino men 36.4 percent, the second-highest group. Black women at 23.1 percent had the highest rate among women.⁵

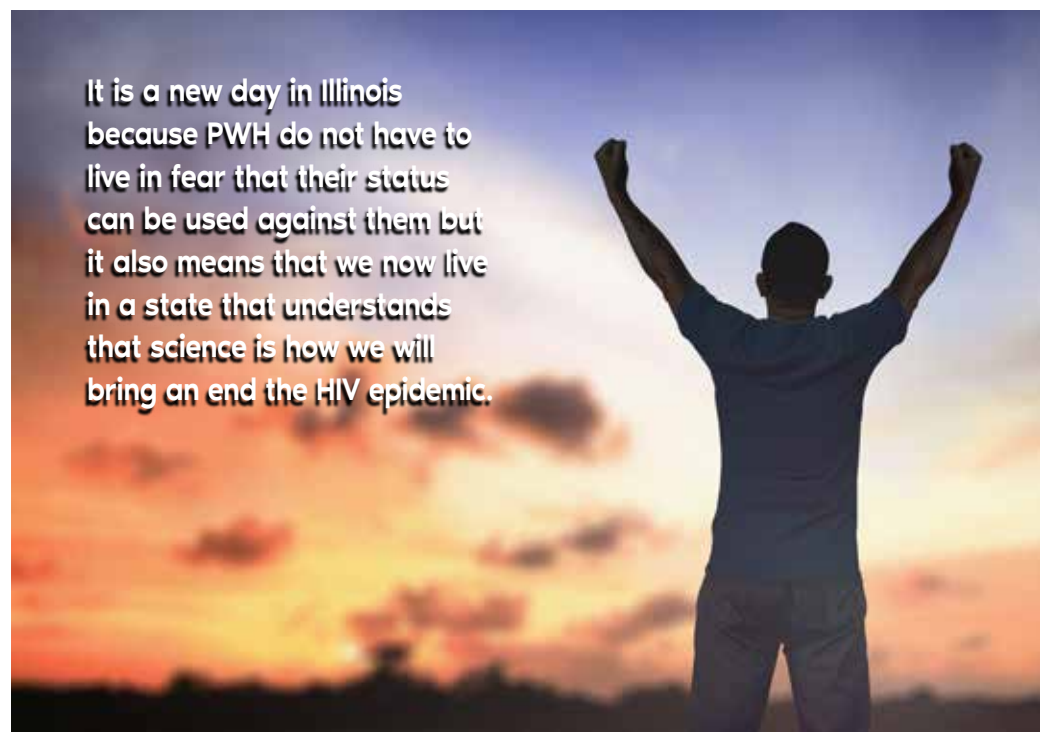
These numbers are impacted by the social determinants of health such as poverty, education and HIV criminalization. Rather than focusing on the real contributors to the epidemic, HIV transmission laws are used as another form of incarcerating the most marginalized communities. Because disclosure is crucial to prosecutions, many people choose not to get tested and know their status.⁶ Disclosing one's status is not only about sexual health but also mental health benefits because it creates dialogue. If we can ever end the epidemic, we must feel comfortable having honest conversations around sexual health. But HIV Criminalization laws have weaponized disclosure by turning something that should be freeing into a fear that leads to inflammatory or ill-informed media coverage that may perpetuate misinformation regarding modes of HIV transmission even though HIV has become a chronic disease that can be controlled with a daily regimen of antiretroviral medications.

An example of ill-informed media coverage can be found in a case where an Illinois man was charged with trying to expose a

police officer to HIV by biting him.⁷ This man's name was printed in papers and his photo was shown to the public. These laws sensationalize and plant fear that PWH are dangerous and must be controlled even when the threat of exposure to HIV is low or nonexistent.

For most HIV transmission laws, transmission is not needed to prosecute. In 2018, the AIDS Foundation of Chicago (AFC) decided to develop a community survey to find out what PWH knew about the laws in Illinois. They found that the communities that knew more about the laws were based on socioeconomic status. White gay men were more aware of the transmission laws than non-whites even though history had shown that Black gay men, trans women, and Latinx people were at a higher risk of being charged.

In the fall of 2018, AFC continued its community outreach in the form of focus groups on HIV criminalization in Illinois as a part of a multi-step process to gather information from communities across Illinois to aid in statewide advocacy. The focus groups targeted PWH who represented communities from Black gay men, MSM, Latinx, Black cisgender women, sex workers, trans-identified and re-entry populations. They were held in a community setting where participants received an incentive for attending and discussing a set of evaluation questions. The qualitative data analysis was performed on Dedoose through qualitative thematic coding of the transcripts based on six key domains. The overall theme of the focus group discussions was categorized into six key themes. These themes were selected based on the evaluation questions asked by the interviewers and the response trends of the participants. The key domains were as follows: knowledge of HIV, knowledge of HIV laws, feelings about HIV laws, the impact of HIV laws, changing the laws, and specific actions needed to change the laws.



Some of the things we learned through these conversations were the lack of basic knowledge about HIV and its transmission. The participants discussed the lack of education regarding HIV and transmission and that PWH often feel discriminated against because there isn't enough awareness about the virus. Since factors such as intent to transmit the disease and obtaining consent from a sexual partner are difficult to prove in court, many participants felt like the laws were vague and not specific enough to either protect or prosecute. Some participants in the focus groups supported the law because it made them feel protected. Others felt the laws were discriminatory and did more harm than good. They strongly felt that a decriminalization of the virus needs to happen to remove its stigma.

The HIV laws in Illinois have impacted people directly and indirectly. Some participants in the focus groups mentioned they knew others who were prosecuted due to the law. Others were affected when their status was disclosed due to their sexual partners being prosecuted. This led to humiliation by association as well as deep emotional scarring.

As discussed by the focus group, a consequence of the law is the challenge it presents in HIV testing. The law can prevent some people from getting tested. The fear of being charged keeps many people from finding out their status. Most participants agreed with the modernization of the law since it did not consider medical advancements made in HIV. With prophylactic measures such as pre-exposure prophylaxis (PrEP) and antiretroviral (ARV) medications, people with undetectable viral loads cannot transmit the virus. This was an important point raised during the discussions.

The 2012 amendment to the amendment states that using condoms during sexual intercourse eliminates the intent to transmit the virus. Therefore a person using condoms cannot be prosecuted. Participants, however, raised concerns over this amendment since a condom can break during intercourse, and the virus can still be transmitted.

Participants expressed the need to educate more people about HIV laws to modify or abolish the law. This could be done through similar

focus group discussions and community engagement. PWH need to be educated on the laws and the virus itself. Participants felt like healthcare providers should educate people after testing positive on the criminalization laws. The response trends indicate that most participants in the focus group agreed upon community-wide dissemination efforts to ensure the success of HIV prevention and treatment programs. The lack of education on HIV transmission, criminalization of the virus, and limited support services available prevent many people from getting tested.

Although the two focus groups gave insight into different perspectives essential to understanding the discussion around HIV criminalization, there were limitations to the study. The information gained from a broader range of focus groups would add to the ongoing debate on how people feel about the law. One thing that came from our research was that community engagement would never stop.

With this information the Illinois HIV Action Alliance (IHAA)⁸, a coalition of legal, health, and policy organizations and other advocates working together to end social stigma and criminalization surrounding HIV, decided that a full repeal of the HIV transmission in Illinois was the first step in bringing an end to the HIV epidemic. Starting in the summer of 2020, IHAA continued to do community outreach and education through a series of events called "Munch and Learns." These online zoom conversations were developed to educate specific communities on the harms that HIV transmission laws have caused and why repealing these bills was needed here in Illinois. These communities included Black gay men, MSM, Black cisgender women, Latinx communities, sex workers, trans-identified, immigrant communities, and older adults.⁹

This type of community engagement and commitment to education is one of the reasons we were able to fully repeal the HIV-specific laws. Due to years of educating legislators, we were able to counter-arguments raised when it came to why the law needed to be repealed.

Now that the law has been repealed in Illinois, we face the challenging part of implementation, which means more community engagement and education. IHAA

has come up with a statewide education and outreach plan to reach each of the eight regions in the state to educate the community on their rights as PWH and how they can protect themselves. It is a new day in Illinois because PWH do not have to live in fear that their status can be used against them but it also means that we now live in a state that understands that science will end the HIV epidemic. **HIV**



COLEMAN GOODE is originally from Texas where he studied music education at Texas Tech University before moving to Illinois in 2002. Prior to joining AFC, Coleman was the chief of staff for Illinois State Representative Greg Harris. He brings eight years of policy work experience, and has developed a passion for helping marginalized communities including but not limited to communities of color, LGBTQ+, sex workers and homeless youth achieve full health equity. Coleman also brings to his work the shared experience of homelessness, living with mental illness and recovery from substance use. He has been living with HIV since 2006 and seeks to build institutions that not only recognize Black humanity, but maximizes the individual and collective liberties of Black people.

REFERENCES

1. Public Law 101-381: Ryan White Comprehensive AIDS Resources Emergency Act of 1990. <http://history.nih.gov/research/downloads/PL101-381.pdf>. Accessed 3 Mar 2014.
2. Map: HIV Criminalization in the United States, The Center for HIV Law and Policy (updated July 2020) <https://www.hivlawandpolicy.org/sites/default/files/HIV%20Criminalization%20in%20the%20US%20%282020%29.pdf>
3. See e.g., Ramon Gardenhire, How Illinois' HIV Criminalization Law Has Changed, AIDS Foundation of Chicago (July 27, 2012), <https://www.aidschicago.org/page/news?id=522>
4. DAN PETRELLA, Chicago Tribune: Illinois repeals law criminalizing HIV and expands coverage for infertility treatment to LGBTQ couples and single would-be parents (July 27, 2021) <https://www.ilhivactionalliance.com/news-1/chicago-tribune-illinois-repeals-law-criminalizing-hiv-and-expands-coverage-for-infertility-treatment-to-lgbtq-couples-and-single-would-be-parents>
5. CDC Accessed February 2020 AtlasPlus | NCHHSTP | CDC
6. Galletly CL, Pinkerton SD. Conflicting messages: how criminal HIV disclosure laws undermine public health efforts to control the spread of HIV. *AIDS Behav*. 2006;10:451-61.
7. Associated Press, Illinois man charged with trying to give officer HIV by biting him. <https://fox59.com/news/illinois-man-charged-with-trying-to-give-officer-hiv-by-biting-him/>
8. Illinois HIV Action Alliance IL HIV Action Alliance
9. Facebook, Illinois HIV Action Alliance, (8) Illinois HIV Action Alliance | Facebook

DEMANDING

EARLIER THIS YEAR, networks of people with HIV (PWH) in the United States came together as the U.S. People Living with HIV Caucus (HIV Caucus) to outline their policy agenda for the federal response to the HIV epidemic. They released the report *Demanding Better: An HIV Federal Policy Agenda by People Living with HIV*, which provided an insightful perspective of the underlying challenges for ending the epidemic as experienced PWH.

The eight national networks of PWH that wrote the *Demanding Better* agenda were: Global Network of PLHIV—North America, International Community of Women—North America, National Working Positive Coalition, Positively Trans, Positive Women's Network—USA, The Reunion Project, Sero Project, and THRIVE SS. These networks are organized formations created, led by, and accountable to the estimated 1.1 million PWH in the United States. They are vehicles through which PWH can define their agenda, choose their leaders and speak with collective voices.

For stakeholders in the federal government, the HIV Caucus brings a unique lens, informed by lived experience, to developing policies to ensure better care, treatment and quality of life for PWH. The networks which make up the HIV Caucus have been involved as service providers, have run programs that serve PWH, and have built community-based organizations and advocacy initiatives from the ground up. They are in direct contact with tens of thousands of PWH throughout the United States. These unique abilities and access inform their work and led them to create this living policy agenda to collect their expertise into a road map for lawmakers and other key stakeholders to use address the HIV epidemic at the federal level.

The policy agenda contains recommendations in five areas which must be centered in every aspect of the federal HIV response:

- Concretely elevating the meaningful involvement of people with HIV and disproportionately impacted communities in the HIV response;
- Proactively creating an affirming human rights environment for people with HIV by addressing stigma, eliminating HIV criminalization, and halting molecular HIV surveillance;
- Addressing inequities in the federal response by attending to racial and gender disparities;
- Adding sex workers and immigrants with HIV as priority populations throughout the federal response; and
- Affirmatively committing to improving quality of life for people with HIV.

To address each of these issue areas, the report calls for concrete recommendations for the associated executive agencies, the HIV National Strategic Plan, and the Ending the HIV Epidemic (EHE) (See table at right).

The federal domestic HIV response can be strengthened through true partnership with PWH networks. The collective voices and organized leadership of PWH, as represented in national and local PWH networks, must be viewed as essential to crafting or changing HIV policy; prevention, care, and treatment guidelines; data collection and surveillance practices; the HIV research agenda; in the design of HIV service delivery; and in all aspects of monitoring and evaluation. The best way to achieve this is by consulting and involving PWH networks as critical stakeholders and partners at every

policy and program decision-making level that profoundly affects their lives.

Meaningful involvement of people with HIV/AIDS (MIPA) is a globally recognized principle first articulated in the Denver Principles in 1983 and endorsed by the United Nations Programme on HIV/AIDS (UNAIDS), the body that coordinates global action on the HIV/AIDS epidemic. As UNAIDS explains, at its most basic level, MIPA does two important things:

1. Recognizes the important contribution that people with and affected by HIV/AIDS can have in response to the epidemic as equal partners; and
2. Creates space within society for involvement and active participation of PWH in all aspects of that response.

True MIPA requires resources, planning and accountability, and these must be included in the plan with commensurate metrics, indicators, strategies, and funding.

To read and find out more about the *Demanding Better: An HIV Federal Policy Agenda by People Living with HIV*, visit www.seroprospect.com. **HIV**

THE US PLHIV CAUCUS (also known as "the HIV Caucus" or "Caucus") is comprised of organizations, coalitions, networks or client groups of people living with HIV, ("institutions") and independent advocates living with HIV. The HIV Caucus collectively speaks with a unified voice for people living with HIV in the U.S. At present the HIV Caucus is an unincorporated association of interested parties and does not have a corporate non-profit status."

BETTER

An HIV federal policy agenda by people living with HIV

Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response

Staff federal bodies addressing the epidemic, such as the Office of National AIDS Policy, with people living with HIV from the communities most impacted by the epidemic and recharter the HIV advisory boards of the federal agencies to include a minimum of two seats for representatives of the HIV Caucus.

Develop a process to solicit input from, engage and consult with the HIV Caucus, and include meaningful involvement of people living with HIV indicators in the final version of the HIV National Strategic Plan and in updates to the Ending the HIV Epidemic Plan.

Proactively creating an affirming human rights environment for people living with HIV

Identify stigma-reduction activities that partners in the HIV response can engage in, require Ending the Epidemics jurisdictions to create plans that incorporate these activities, and resource people living with HIV networks to develop and implement stigma-reduction initiatives.

Utilize data collection tools and interventions that examine structural change.

Promote advocacy efforts to remove punitive laws and policies, like HIV criminalization, by acknowledging the federal government's role in creating them and making clear commitments in federal plans to end HIV criminalization.

Declare a moratorium on molecular HIV surveillance and partner with people living with HIV networks to develop standards for obtaining informed consent; privacy protections; and security, sharing, and storage protocols.

Implement community generated standards in all aspects of the federal HIV response and ensure funding is in place for training and compliance.

Addressing inequities in the federal response: attend to racial and gender disparities

Explicitly include racial and gender disparities as elements of the HIV epidemic to be addressed in all funding opportunities and create grant opportunities for and led by these populations.

Require Ending the Epidemic jurisdictions to target resources to Black, Indigenous, and other people of color, especially those who are also gay and bisexual men, people of trans experience, people who use drugs, sex workers, and immigrants.

Require jurisdictions and grantees to provide care services to dependents while people living with HIV receive services and to screen for intimate partner violence.

Adding sex workers and immigrants living with HIV as priority populations throughout the federal response

Push to prohibit the practice of using condom possession as evidence of sex work and eliminate federal policies conflating sex work and human trafficking.

Prioritize and require commitments to the decriminalization of sex work, including restrictions of individuals with sex work-related or drug-related convictions from accessing federal programs and services.

Ensure health care is accessible regardless of immigration status.

Add sex workers and immigrants as priority populations in the federal HIV response and fund programs led by and serving them accordingly.

Fund language services, particularly those that are in-person, and require certain grantees to staff certified medical interpreters or train staff on interpretation utilization.

Affirmatively commit to improve quality of life for people living with HIV

Create a minimum standard of care and quality of life for people living with HIV, promulgate regulations requiring those providing health care to people living with HIV to conform to those standards, and monitor and report how these standards are being upheld.

Establish access to online and in-person benefits counseling/ advisement for people living with HIV; design system to improve portability of benefits between jurisdictions; and create programs to train, recruit, and hire people living with HIV into the HIV workforce and other employment opportunities.

Fully fund Housing Opportunities for People with AIDS and other federal housing programs and enforce the Fair Housing Act to address housing discrimination.

Require the federal HIV programs to track and address housing for people living with HIV.

Improve the Supplemental Nutrition Assistance Program to account for regional differences, increase overall benefits, continue extensions of work requirements, and reduce administrative burdens for people living with HIV.

Improve, expand, and fund access to sexual and reproductive health care for people living with HIV, including transition-related care, and monitor this progress with metrics in the federal HIV response.

Fund research and create accessible guidelines for birthing people living with HIV to breast/chest-feed their children that do not include criminalization.

HIV and Race in America


Making a case for equity and racial justice

By: Leonard Sowah, MBChB, MPH, FACP

THE COVID-19 PANDEMIC threw a bright light on the glaring disparities in our society. The obvious disparities in incidence and mortality of this virus by race and ethnicity had some looking for a biological element. Many of us with experience working with minorities and the underserved populations suspected social determinants even before the data were clearly conclusive.

One study with COVID-19 data from 28 states reported significant relative mortality risks by race, comparing African Americans to White people ranging from 1.67 (95% CI: 1.25–2.17) in Ohio to 18.52 (95% CI: 14.46–23.07) in Wisconsin.¹ Aggregate mortality rates comparing African Americans to White people nationwide for this study was 3.57 (95% CI: 2.84–4.48) suggesting that in the early days of the pandemic, African Americans were more than 3.5 times more likely to die of this disease compared to White people. This report drew a lot of attention in the lay media and opened the eyes of America to differences in life experiences by race in this country. HIV transmission and diagnosis rates had followed a similar pattern over the decades raising several questions on race, sexuality, and social justice.

Racial and ethnic disparities in disease incidence and outcomes have always been evident to us in the HIV community. In the early HIV pandemic, the new disease appeared to be associated with gay men, Haitian people, and heroin users. These easy associations allowed many to maintain a false sense of safety while at the same time reinforcing a sexual prejudice against homosexuals.² Nowadays, disparities in HIV rates by race and ethnicity across the U.S. is well recognized and closely tracked by the Center for Disease Control and Prevention (CDC). CDC surveillance data suggests that this disparity shows a downward trend but persists.³ A recent article in *The Lancet* revealed that in 2017, the HIV prevalence rates among African American women was 17.6 times higher compared to White women.⁴



Insurance coverage
has improved with the
Affordable Care Act and
Medicaid expansion.
However, most southern
states opted out.

These variations in HIV prevalence and incidence rates by race and ethnicity show a geographic concentration in southern U.S. states.⁵ The question that researchers and policymakers seek to know is, “What are the underlying factors driving these disparities?” That question may appear simple but has many intervening drivers and contextual issues, making it difficult to answer conclusively. Some look to the biology of the virus and racial ‘genetics.’ Many of those with experience caring for this community only see unequal social and sexual risks and racial justice as significant drivers of this disparity. This article will attempt to distill out and to clarify some of these factors.

Social Networks and HIV Risk in African American Communities

One clear explanation for the higher rates of HIV in African American communities is the differences in community viral load (CVL). This is described as the estimated cumulative burden of HIV viremia in a community. In one study using data from South Carolina’s enhanced HIV/AIDS Reporting System, which looked at CVL by race and gender, African Americans had higher CVLs than White people. This CVL data was reflective of the higher rates of HIV among African Americans in that state, representing close to 70 percent of all cases.⁶ This reflects the impact of social networks on HIV risk. Thus, disparities in HIV risk by race comparing African Americans to White people may be partly explained by differences in CVL. At the community level, the difference in access to HIV treatment secondary to local and state-level laws and regulations affecting low-income Americans also drives up CVLs in African Americans.

Access to medical services in the U.S. is complex, convoluted and differs by state. The patchwork of services and programs supporting low-income, marginally-insured Americans is even more of a mystery and is ever-changing. A study among White and African American men who have sex with men (MSM) used CDC surveillance and treatment data for people with HIV (PWH) from 2009 -2010 to document this disparity. This study revealed that disparities favored White MSM within all steps of the HIV care continuum. This resulted in a transmission rate of 3.99 per 100 in White MSMs compared to 5.45 per 100 in African American MSM, with an estimated eight percent versus 32 percent positivity rate in the White population compared to the African American population. This translated to 9,833 new transmissions in the African American group versus 9,710 in the White group. This is an alarming situation considering the six-fold difference in population sizes.⁷

This differential risk of HIV transmission by race is even more pronounced in the heterosexual population. Race incongruent aggressive policing techniques affecting African American males is a major contributing factor to social network instability due to the jail to community revolving door.⁸ This can drive specific behavioral risks affecting HIV risk among African American women. Studies show that African American women are more likely to report higher numbers of lifetime sexual partners and sexual concurrency, both factors being independently associated with HIV risk.^{9,10} These factors, lower rates of healthcare coverage, late diagnosis of HIV, and other sexually transmitted infections (STIs) potentially, modulate African American societal risk. Contextual factors such as unstable communities with



Over the past few years, the U.S. has started taking a closer look at structural racism and equity, potentially ushering in a new wave of change in issues of race in this country.

frequent cycling within social and sexual networks influence network complexity and independently drive-up risk.¹¹

For various reasons, it is well established that the male to female sex ratio for African American adults nationally is below 0.90 (i.e., < 90 men for every 100 women). In addition, most U.S. metropolitan areas have inequitable sex ratios for African American adults with a median of about 0.88.¹² All these social and environmental factors contribute in various ways to create dense and high turnover networks with significant HIV risk for African American heterosexuals. This explains, in part, the more than 17-fold higher diagnosis rates of HIV when comparing African American to White women.

The Prison Industrial Complex and Social Networks

Mass incarceration due to the war on drugs has affected almost all aspects of life in poor African American communities. From 1980 to 2016 prison population saw an upward trend from 1980 to 2008. This trend has since plateaued and has shown a drop primarily due to a 26 percent decrease in incarceration for drug-related offenses.¹³ Racial profiling

and the disproportionate use of force in policing minorities, resulted in significant disparities in arrests of African Americans. While reports suggest that only 14 percent of drug users are African American, 34 percent of drug-related arrests and 40 percent of all drug convictions and state sentences are of African Americans persons.¹⁴ Since then, minorities, mostly African Americans and members of the Latino and Hispanic communities accounted for 80 percent of those in federal prison and almost 60 percent of people in state prison for drug offenses. Also, prosecutors have been twice as likely to pursue a mandatory minimum sentence for an African American defendant compared to White offenders.¹⁵

The link between mass incarceration and its disproportionate impact on African American males and HIV rates is not conclusive. Still social epidemiologists and anthropologists believe there is a contextual link.¹⁶ One study across nine cities in the southern U.S. saw an association between high prison release rates and five-year HIV diagnosis rates especially among African American males.¹⁷ A similar study based on modeling data from Philadelphia from 2005 to 2015 suggested that mass incarceration of African American men can substantially increase HIV transmission to African American women.¹⁸ Post-release

high-risk behaviors and delays in establishing care post-transition are identified drivers. African American male incarceration is highest in the south. Insurance coverage has improved with the Affordable Care Act and Medicaid expansion. However, most southern states opted out. In a recent study of the Women's Interagency HIV Study (WIHS), participants revealed that barriers to HIV treatment specifically lack of insurance, and high incarceration rates, are underlying causes of poor HIV-related outcomes in the south.¹⁹

Is the Current Policy Focus on Structural Racism a Ray of Hope?

Over the past few years, the U.S. has started taking a closer look at structural racism and equity, potentially ushering in a new wave of change in issues of race in this country. Unfortunately, while some believe racial justice is necessary, others think the emancipation proclamation was enough. As a physician, I hope for a world where people are not forced to make choices that increase their risk of HIV.

A healthy non-adversarial relationship between policing and our communities has health implications and must be prioritized. Also, living in a nation where access to good healthcare for all people irrespective

of socio-economic status has a significant impact on health. In HIV and disease control, a lot will need to be done. Again, the data linking high incarceration rates and HIV transmission rates are inconclusive. Unfortunately, waiting for conclusive data to act in such a high-stakes situation can be disastrous.

It is imperative that all state and federal authorities involved in disease control and prevention, including the legal and justice departments, will need to consider these associations seriously and start working towards solutions. Interventions that focus on testing and context-appropriate treatment in jails and prisons can help shed more light on incarceration and HIV risk while also addressing the systemic problems within. The U.S. health system will need to develop new innovative strategies that favor equity and improve our systems for the benefit of all Americans. **HIV**



DR. LEONARD SOWAH is an internist with several years of experience serving low-income communities with a high burden of HIV. In his work, he has had the opportunity to interact with patients and other providers with intimate knowledge of the workings of HIV screening, prevention, and care in our prison system.

REFERENCES

- Gross, C. P., Essien, U. R., Pasha, S., Gross, J. R., Wang, S. Y., & Nunez-Smith, M. (2020). Racial and ethnic disparities in population-level Covid-19 mortality. *Journal of general internal medicine*, 35(10), 3097-3099.
- Herek, G. M., & Capitanio, J. P. (1999). AIDS stigma and sexual prejudice. *American behavioral scientist*, 42(7), 1130-1147.
- Bradley, E. L., Williams, A. M., Green, S., Lima, A. C., Geter, A., Chesson, H. W., & McCree, D. H. (2019). Disparities in incidence of human immunodeficiency virus infection among Black and White women—United States, 2010–2016. *Morbidity and Mortality Weekly Report*, 68(18), 416.
- Sullivan, P. S., Johnson, A. S., Pembleton, E. S., Stephenson, R., Justice, A. C., Althoff, K. N., ... & Beyrer, C. (2021). Epidemiology of HIV in the USA: epidemic burden, inequities, contexts, and responses. *The Lancet*.
- Townes, A., Lyons, S. J., & McCree, D. H. (2021). Changes in Diagnoses of Heterosexually Acquired HIV Infection Among Black/African American Males and Females in Seven Southern United States, 2014–2018. *Journal of Racial and Ethnic Health Disparities*, 1-6.
- Chakraborty, H., Weissman, S., Duffus, W. A., Hossain, A., Varma Samantapudi, A., Iyer, M., & Albrecht, H. (2017). HIV community viral load trends in South Carolina. *International journal of STD & AIDS*, 28(3), 265-276.
- Rosenberg, E. S., Millett, G. A., Sullivan, P. S., Del Rio, C., & Curran, J. W. (2014). Understanding the HIV disparities between black and white men who have sex with men in the USA using the HIV care continuum: a modelling study. *The lancet HIV*, 1(3), e112-e118.
- Metzger, K., & Cuppari, V. (2020). The "Revolving Door" of Mass Incarceration: What Keeps Baltimore City Safe?.
- Aral, S. O., Adimora, A. A., & Fenton, K. A. (2008). Understanding and responding to disparities in HIV and other sexually transmitted infections in African Americans. *The Lancet*, 372(9635), 337-340.
- Moreno, C. L., El-Bassel, N., & Morrill, A. C. (2007). Heterosexual women of color and HIV risk: Sexual risk factors for HIV among Latina and African American women. *Women & health*, 45(3), 1-15.
- German, D., & Latkin, C. A. (2012). Social stability and HIV risk behavior: evaluating the role of accumulated vulnerability. *AIDS and Behavior*, 16(1), 168-178.
- Ibragimov, U., Beane, S., Adimora, A. A., Friedman, S. R., Williams, L., Tempalski, B., ... & Cooper, H. L. (2019). Relationship of racial residential segregation to newly diagnosed cases of HIV among black heterosexuals in US metropolitan areas, 2008–2015. *Journal of Urban Health*, 96(6), 856-867.
- Ghandnoosh, N. (2019). US prison population trends: Massive buildup and modest decline. *The Sentencing Project*.
- Bobo, D. L., & Thompson, V. (2010). Racialized mass incarceration: Poverty, prejudice, and punishment. *Doing Race: 21 Essays for the 21st Century*. New York: Norton, WW & Company, Inc.
- Drug Policy Alliance, (2018, January 2018) The Drug War, Mass Incarceration and Race. https://drugpolicy.org/sites/default/files/drug-war-mass-incarceration-and-race_0118_0.pdf. assessed October 10th, 2021
- Pouget, E. R., Kershaw, T. S., Niccolai, L. M., Ickovics, J. R., & Blankenship, K. M. (2010). Associations of sex ratios and male incarceration rates with multiple opposite-sex partners: potential social determinants of HIV/STI transmission. *Public health reports*, 125(4_suppl), 70-80.
- Ojikutu, B. O., Srinivasan, S., Bogart, L. M., Subramanian, S. V., & Mayer, K. H. (2018). Mass incarceration and the impact of prison release on HIV diagnoses in the US South. *PloS one*, 13(6), e0198258.
- Adams, Joëlla W., et al. "Potential drivers of HIV acquisition in African-American women related to mass incarceration: an agent-based modelling study." *BMC public health* 18.1 (2018): 1-11.
- Ludema, Christina, et al. "Comparing neighborhood and state contexts for women living with and without HIV: understanding the Southern HIV epidemic." *AIDS care* 30.11 (2018): 1360-1367.

The background is a dark, blue-tinted photograph of a street scene. In the foreground, there is a large, semi-transparent red silhouette of a woman standing with her back to the camera, wearing a short dress and high heels. To the left, the lower half of another person is visible, walking away. The overall mood is somber and evocative.

The Omission of

SEX WORKERS

from the Federal
Response to the
HIV Epidemic

By: Chauncey McGlathery

FEDERAL POLICY NEVER HAPPENS WITHIN A VACUUM. Even something as critical as the federal response to the HIV epidemic is created with conflicting agendas in mind. In today's climate of sexism, racism, and the criminalization of poverty, the failure to protect sex workers is par for the course. Over the last forty years of battling against this epidemic, the federal response has been corrupted by an apathetic disregard for the lives of sex workers whose lives are often upended by the HIV epidemic.

For the first 30 years of combatting HIV, our nation had no national plan to address the epidemic. The programs and policies administering healthcare and treatment to people with HIV (PWH) collectively formed a hit-and-miss approach. However, the Obama administration took the bold step of releasing a national response to HIV in July 2010, which it dubbed the National HIV/AIDS Strategy for the United States (NHAS).¹ This strategy explicitly required coordination by several federal agencies along with stakeholders' involvement in both the private and faith sectors.

In 2015, the NHAS was revised to emphasize increasing HIV testing and linking people who tested positive to care.² With a 2020 timeframe for goal achievement and new metrics, this strategy supported retaining PWH in care, achieving viral suppression, and focusing efforts on the populations most impacted by HIV. However, no mention was made of sex workers or the unique circumstances that keep them at risk.

Ending the HIV Epidemic Plan

In January of 2019, the Department of Health and Human Services (HHS) announced a plan to reduce new cases by 75 percent by 2025, and 90 percent by 2030.³ This plan, known as the Ending the HIV Epidemic Plan (EHE), requires that the federal government respond to "potential HIV outbreaks to get needed prevention and treatment services to those who need them."⁴

PWH networks believe that the EHE is overly focused on biomedical research. Meanwhile, almost no attention is paid to the underlying social and structural issues that put communities at risk. Additionally, the EHE is also faulted for its failure to call for a partnership with PWH networks to develop an effective plan and budget that will result in meaningful involvement of people living with HIV/AIDS (MIPA) at all levels of government.⁵

National HIV/AIDS Strategy

HHS released a draft of a third version of the National HIV/AIDS Strategy with the intent to align the national strategy with the EHE initiative.⁶ During the brief public comment period, PWH networks

highlighted the following shortcomings in the new plan:

- The continued failure to involve PWH networks in the development of the plan;
- The plan's inclusion of HIV genomic sequencing data, cluster detection, and data derived from molecular HIV surveillance, gathered without consent.
- The lack of attention to the quality of life of PWH; and
- The notable absence of immigrants and sex workers in the plan.⁷

When the plan's final version was released in January of 2021, this feedback was largely ignored. As a result, a new set of policy recommendations is now demanded that will consider broader systems within which this federal response is located. This collection of recommendations is known as "Demand Better: An HIV Federal Policy Agenda by People Living with HIV."⁸ This document lays out a clear roadmap for the administration, Congress and federal agencies to achieve their goal of ending the HIV epidemic by 2030 with the additional benefit of improving the quality of life for PWH.

National HIV Strategy of the Biden Administration

When the Biden Administration delivered the fourth iteration of our federal policy on World AIDS Day, December 1, 2021, it had the opportunity to finally redress its omission of sex workers as a priority population in ending the epidemic as none of the previous statements have mentioned sex workers in any way whatsoever. Unfortunately that didn't happen.

With this new administration and with what some consider to be a progressive director of HHS, PWH networks hoped that sex workers might finally be included in their critical place. However, the 2021 NHAS did not include sex workers. When asked directly about this particular urgency, the CDC reportedly insists that it doesn't have the necessary research data it needs to include sex workers among the other priority populations. It does not appear that this failure of inclusion is merely an oversight, but is a part of a larger conspiracy to ignore what is a political landmine, given our current paralysis of polarization.

Federal Policy's Confusion of Sex Workers and Sex Trafficking

Like many current movements within the United States, the anti-trafficking movement is led by a corporate conglomeration of influential organizations.⁹ However, contrary to popular belief, there is in fact no conflict between the movement to protect sex workers and the movement to end human trafficking.¹⁰ Sex workers recognize the specific interest in ending human trafficking with deliberate speed. However, in its zeal to curry favor with the corporate establishment, the anti-trafficking movement leaders have reached beyond the boundaries of their crisis and jeopardized the health and safety of sex workers in the process.

The anti-trafficking movement leaders call themselves "abolitionists," organized to end "modern-day slavery."¹¹ Although these words sound laudable to the establishment, their import is overly broad and unnecessarily confusing. This confusion lends itself to the error many inside and around this movement continually make of conflating sex work with sex trafficking. This confusion is further perpetuated by common myths of the anti-sex trafficking movement, the first of which is that all people being sex trafficked are cisgender women.¹²

The federal approach to addressing the prosecution of sex work is now changed to embrace a philosophy referred to as "End Demand."¹³ End Demand is an economic concept by which the legal system attempts to destroy the market for sex work by criminalizing acts on the "buyer" side. They magically believe that once they end demand by the threat of overreaching prosecution, the supply will disappear, or so the theory goes. Additionally, to support this mythology, the federal government embraces the fallacy that all buyers are men and all sex workers are women.¹⁴

Queer and transgender people are notably absent from this strategy, not only as a significant portion of the sex working "sellers," but also as a population exposed to an even greater risk of harm under this strategy.¹⁵ Further, this exclusion demonstrates how cruel, dangerous and out-of-touch the anti-trafficking movement is with the everyday risks and injustices of national public health policy pervasive since its inception. In reality, some of the greatest examples of harm and threat experienced by sex workers are not found among cisgender Caucasian women but transgender women of color, particularly African American trans women.¹⁶

Sex Workers During the COVID-19 Pandemic

To make matters even worse, the crisis experienced by sex workers has significantly worsened during the pandemic.¹⁷ Traditionally, sex work is virtually impossible in a state of social distance. By March of 2020, hundreds of thousands of sex workers faced not only the impossibility of employment but also stigma and discrimination as they struggled to find relief.¹⁸ Whereas workers in other industries could count on their employers to mitigate the damage to their displaced workers, sex workers were left to their own devices to fend for themselves.¹⁹

Thus, the unprecedented health and economic crisis have demonstrated the dire vulnerability of all low-wage and gig workers in the United States.²⁰ The experience of sex workers is not the exception to this rule. Sex workers cannot access public assistance and are not likely to find social services without risking arrest. Just as undocumented



workers and prison laborers receive no government benefits for their labor and little consideration for their humanity, sex workers have few places to turn for help.²¹

Federal law explicitly prohibits disaster loans or grant assistants to those who earn income “through the sale of products or services, or the presentation of any displays” and those who “present live performances of a prurient sexual nature.” Consequently, sex workers are disqualified from receiving federal relief.²²

The Demise of Online Access for Sex Workers

Even before the pandemic, sex workers came under increasing threat to their livelihood, health and safety with the adult content ban of Tumblr in December of 2018. Although this ban created a chilling effect on the sex industry, its impact on the platform was fatal.²³ Verizon sold Tumblr in 2019 at less than one percent of its purchase price. When the media conglomerate purchased Tumblr as part of a \$4.89 billion acquisition of Yahoo’s internet business in 2017, Verizon saw its participation in the anti-trafficking movement as good for business.²⁴ It sought to eliminate “pornography” to attract more advertisers. This greedy economic power play coincided with the passage of the now infamous and overreach federal laws, FOSTA and SESTA, which were aimed at combatting sex trafficking online.²⁵

The growing graveyard of sites including Backpage and Tumblr were central to the process of self-discovery, but also to the health, safety, and well-being of sex workers nationwide.²⁶ Before Verizon drove away its user base, Tumblr played a critical role in supporting and

connecting historically marginalized sexual communities and others whose livelihood depends on the freedom of sexual speech.²⁷

The Implication of FOSTA-SESTA

A few days after federal authorities shut down Backpage, Public Law 115-164 (FOSTA-SESTA) became law in 2017.²⁸ Although this law purported to reduce human trafficking, the law increased federal pressure on internet platforms to censor their users.²⁹ While anti-trafficking supporters lauded the law, the communities directly impacted claimed that it increased their threat of violence and left them without many of the tools they needed to keep themselves safe.³⁰ Not only has this federal law created overreaching consequences for those who rely on sex work as their primary form of income, but has also had a detrimental effect on their safety and access to better health outcomes.³¹ **HIV**



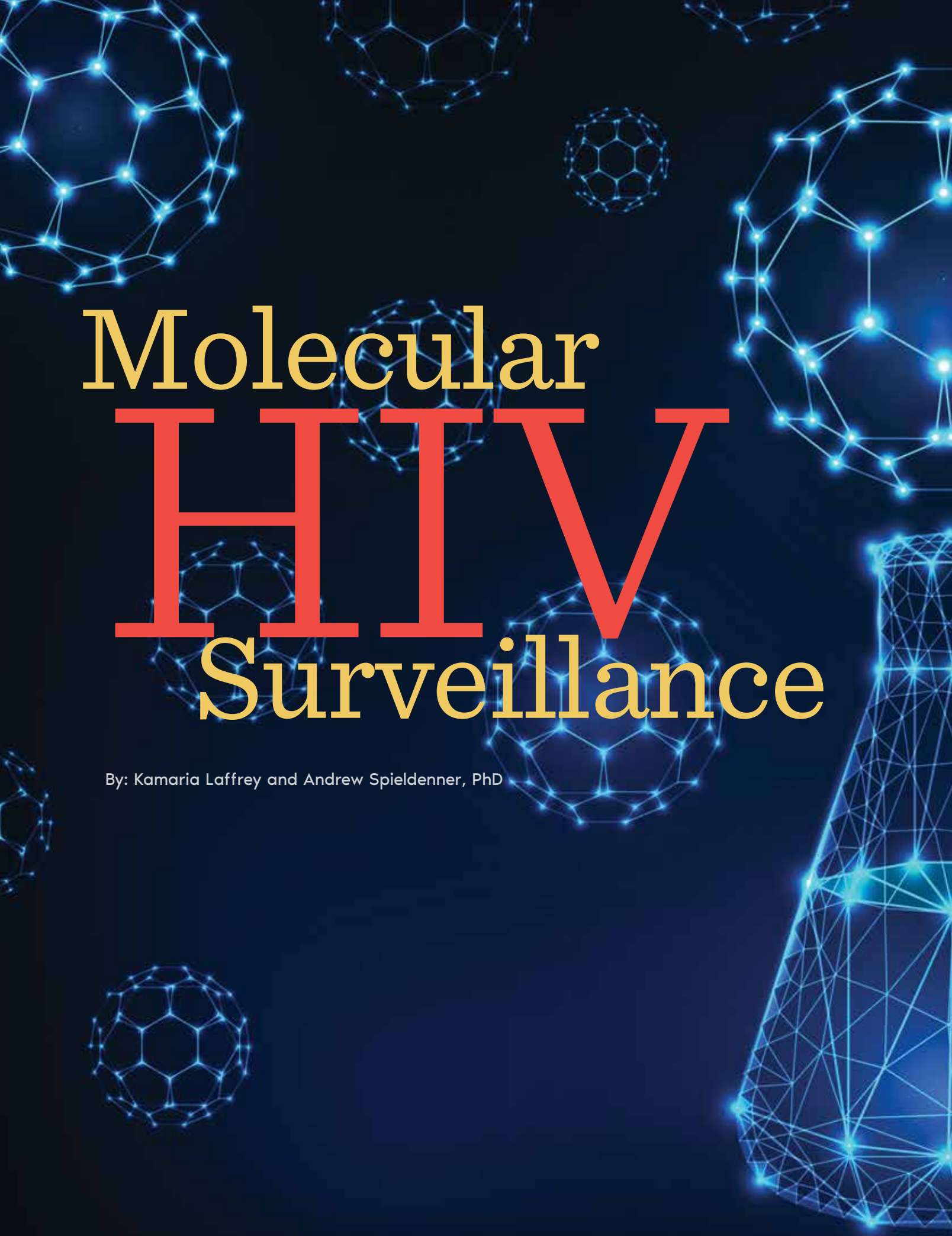
CHAUNCEY MCGLATHERY is the sexual justice coordinator for the Sero Project. She helps develop and implement support within the HIV community for the Safe Sex Worker

Study Act and create a closer alliance between PWH advocates and sex worker communities.

REFERENCES

1. Off. of Nat. AIDS Pol’y, Exec. Off. of the President, National HIV/AIDS Strategy (2010), hivgovprod-v3.s3.amazonaws.com.
2. Off. of Nat. AIDS Pol’y, Exec. Off. of the President, National HIV/AIDS Strategy Updated to 2020 (2015) https://obamawhitehouse.archives.gov/sites/default/files/docs/national_hiv_aids_strategy_update_2020.pdf.
3. Off. of Infectious Disease and HIV/AIDS Pol’y, What Is Ending the HIV Epidemic in the U.S.?, HIV.gov (June 2, 2021), <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>.
4. Id.

5. “Demanding Better: An HIV Federal Policy Agenda by People Living With HIV.” (July 2021), <https://www.pwn-usa.org/demanding-better-an-hiv-federal-policy-agenda-by-people-living-with-hiv/>.
6. U.S. Dep’t of Health and Human Services, HIV National Strategic Plan: A Roadmap to End The Epidemic for the United States 2021-2025 (2021) [hereinafter HIV Plan], <https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf>.
7. The comments expressed serious concern with the draft HIV Plan’s inclusion of the use of HIV genomic sequencing data, cluster detection, and data derived from molecular HIV surveillance. The comments further offered specific ways in which the draft HIV Plan could be strengthened, for example, by adding explicit commitments to employment and economic justice for PLHIV, sexual and reproductive health care for people of all genders living with HIV, and explicitly addressing the prevention, health care, and human rights needs of immigrants, of people of trans experience, and of sex workers. HIV Caucus Comments on National HIV Strategy, U.S. People Living with HIV Caucus (Dec. 13, 2020), <https://www.hivcaucus.org/blog/hiv-caucus-comments-on-national-hiv-strategy>; PWN’s Comment on the Draft HIV National Strategic Plan 2021-2025, Positive Women’s Network (Dec. 17, 2020), <https://www.pwn-usa.org/pwns-comment-on-the-draft-hiv-national-strategic-plan-2021-2025/>.
8. “Demanding Better: An HIV Federal Policy Agenda by People Living With HIV.” (July 2021), <https://www.pwn-usa.org/demanding-better-an-hiv-federal-policy-agenda-by-people-living-with-hiv/>. <?> “Top Myths of the Anti-Trafficking Anti-Sex Work Movement,” <https://www.swopbehindbars.org/post/top-myths-of-the-anti-trafficking-anti-sex-work-movement>
9. Id.
10. Id.
11. Id.
12. Id.
13. Id.
14. Id.
15. Id.
16. Id.
17. “The Fragile Existence of Sex Workers During the Pandemic,” Alexis Okeowo (May 2020), <https://www.newyorker.com/news/news-desk/the-fragile-existence-of-sex-workers-during-the-pandemic>
18. Id.
19. Id.
20. Id.
21. Id.
22. Id.
23. “Pornography, Trans Visibility, and the Demise of Tumblr Discontinuation of Online Access for Sex Workers,” Carolyn Bronstein, (May 2020), <https://doi.org/10.1215/23289252-8143407>.
24. Id.
25. Id.
26. Id.
27. Id.
28. “Eased: The Impact of FOSTA-SESTA 2020 & the Removal of Backpage.” https://hackinghustling.org/wp-content/uploads/2020/02/Erased_Updated.pdf
29. Id.
30. Id.
31. Id.

The background is a dark blue gradient featuring several glowing molecular structures. These structures are composed of interconnected lines and points, resembling carbon nanotubes or fullerenes, and are illuminated with a bright blue light that creates a sense of depth and complexity. The structures are scattered across the frame, with some appearing more prominent than others.

Molecular HIV Surveillance

By: Kamaria Laffrey and Andrew Spieldenner, PhD



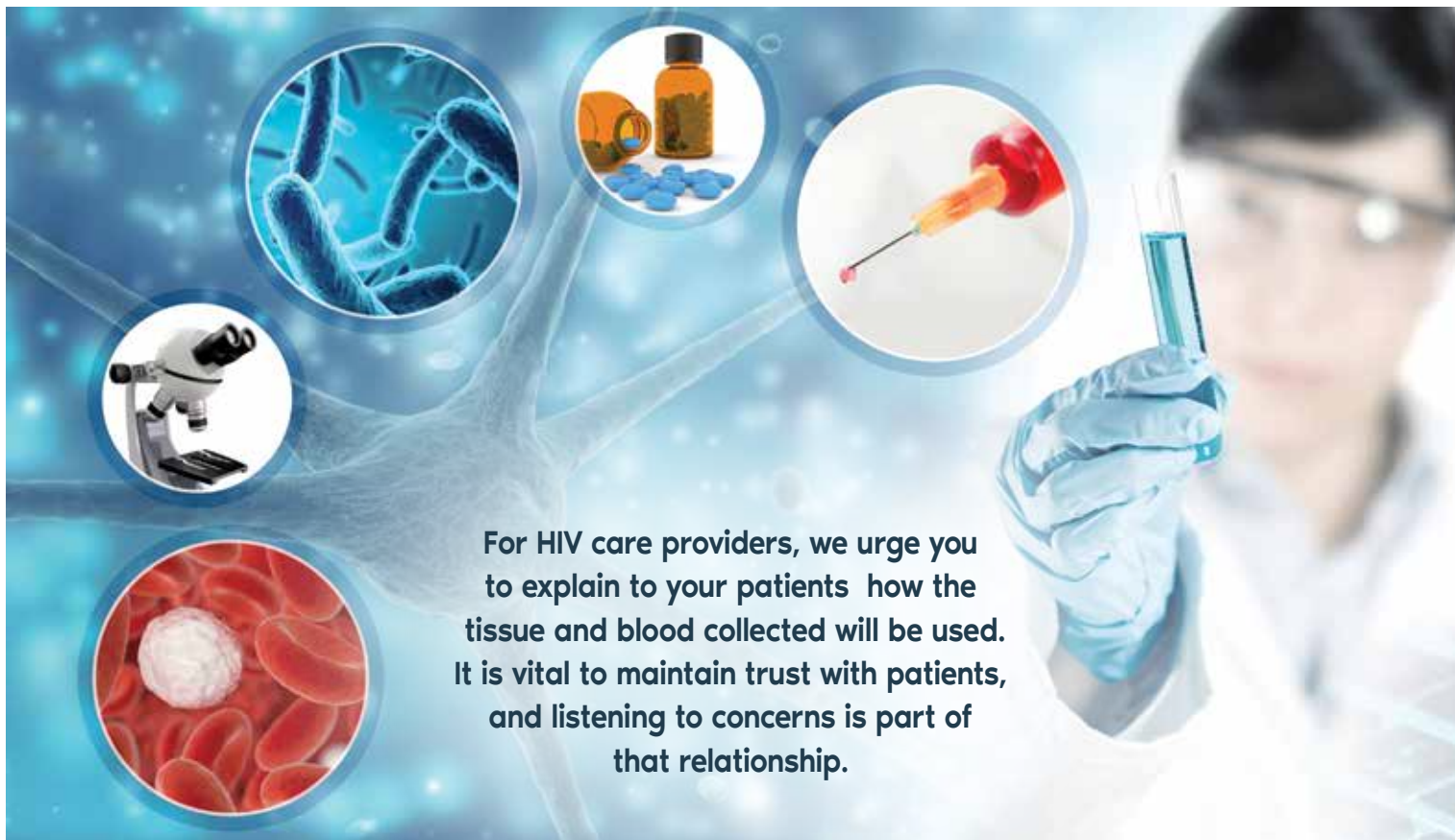
Two sides of the same coin, one path to harm

THE PRACTICE OF MOLECULAR HIV SURVEILLANCE (MHS) was first introduced to the HIV advocacy community in 2018 at the HIV Is Not a Crime Training Academy, a bi-annual event that trains attendees about advocacy, coalition building and grassroots organizing so they can change and modernize HIV criminalization laws at the state level. It was reported at the Training Academy that the Centers for Disease Control and Prevention (CDC) had released a funding announcement for health departments to conduct MHS. At the time, communities of people with HIV (PWH) were uninformed about MHS, but acted quickly to learn more.

Our organizations called for an impromptu meeting on the topic. To be honest, we expected seven or eight other community HIV organizations to show up. Surprisingly, the meeting was standing room only, with over 40 advocates trying to learn more about the potential risks of MHS to PWH. The more the groups learned about the technology, our concern grew. We came to understand MHS procedurally, but were astonished at the blatant disregard for the safety and privacy of people with and vulnerable to HIV. We all concluded that this technology was extremely problematic. The government required that public health data be collected without consent under the guise of protecting and informing “the public” and intervening when there are rapid increases in HIV cases.

Now that the HIV advocacy community is fully aware of MHS, we have actively raised our concerns. At the 2019 AIDS Watch, advocates protested during then-CDC director Dr. Robert Redfield’s presentation. The most visible outcry was the 2019 convening at the U.S. Conference on HIV/AIDS (USCHA) in Washington, D.C., when activists again voiced concerns by taking the stage during Dr. Redfield’s presentation.

Also in 2019, several networks of PWH led a webinar series through the Legacy Project at HIV Prevention Trials Network. At the HIV Is Not A Crime Training Academy in 2021, advocates shared information on how MHS would impact communities, how this data was or wasn’t being used to classify PWH and how MHS would



For HIV care providers, we urge you to explain to your patients how the tissue and blood collected will be used. It is vital to maintain trust with patients, and listening to concerns is part of that relationship.

further criminalize them. The resounding consensus across these sessions was that PWH were concerned with how their bodies were being used without knowledge or consent by redeploying blood used in standard medical care for this other initiative.

To address the lack of informed consent, meaningful engagement, or consultation with PWH in development and implementation of MHS, advocates are pressing for clarity and protections to be put in place. This is especially important when it comes to law enforcement. Entities in charge of this process can and should guarantee that jurisdictions prohibit sharing information gathered through MHS with law enforcement.

It is also essential to ask:

- What guidelines are being implemented to protect immigrant or sex worker communities?
- Is this an actual effective use of federal funding?
- Why are PWH not involved in the development of MHS policies?
- Who does it benefit not to have explicit consent for this technology?

Often the justification to community outcry has been that this type of surveillance has been done for many years and that clients receiving genotype testing had already given consent for it regardless of knowledge of what that entailed.

Since the mid-1800's, spot maps tracking cholera, smallpox and other infectious diseases have been utilized to identify high concentrations of areas impacted by a disease. This process and the systems

of surveillance that branched from it was created prior to the implementation of health privacy laws. MHS is not a type of health data collection that is specifically covered under the Health Insurance Portability and Accountability Act (HIPAA). There are less state and local guidelines on protections for the individual data sharing than those prohibited under the federal HIPAA. Often people sign health consent forms without any discussion or understanding of what rights are being waived.

Also, state-by-state protections on health data laws vary as to what HIV data may be available to courts, prosecutors, and law enforcement agencies. In some states, public health authorities are either required by law or routinely, share information with law enforcement. There are currently not enough protections in place, and what little rights PWH have are being taken away.

Breaches of privacy and confidentiality are serious concerns. State public health departments do not have a perfect track

record for securing confidential data. While public health officials say they remove names from the data that they send to the CDC, the same is not the case for information kept locally. MHS implementers and the public health authorities do not view PWH as part of the “public.” Instead, they are viewed as risks from which the “public” is to be protected. Therefore, the increased systemic harm of this surveillance is not seen as problematic because it is being conducted for the public’s good, discounting the fact that PWH are vital members of the public.

There is a wide variation in state-level data sharing and legal protections for MHS.

Just as there is not a federal beacon to protect PWH from criminalization, there is no current national standard that would uniformly protect this misuse of data. This widely contributes to the medical mistrust already felt by marginalized communities by connecting health data to a systemic body of enforcement that has historically misused power. When it comes to law enforcement, state-by-state protections are not upheld consistently. For instance, when data is used to identify zip codes and neighborhoods where HIV prevalence is high, these communities are often targeted by law enforcement. Often this represents communities already highly surveilled including communities of color, people who use drugs, sex workers, immigrants and other vulnerable marginalized communities.

This inconsistency in data protection creates and sustains the **risk of potential data misuse in civil, immigration, and criminal proceedings**. The U.S. is a leading country in the world for criminalizing PWH. PWH are already in a fight against systemic violence and inequities. While the MHS technology cannot show the direction or direct transmission source, there are still dangers to its use and misuse. We should not have to wait for worst-case scenarios to emerge for our concerns about MHS to be addressed.

The demand to stop funding Ending the HIV Epidemic (EHE) jurisdictions from conducting MHS surveillance is one of

the many recommendations being made. When funding is already being prioritized to address “high-risk populations,” the need for MHS feels excessive, violent and unnecessary. There are concerns that funding is being stretched across already scarcely resourced programs. This funding could be better used to provide housing, transportation or increased access to affordable and quality care, especially in the southern U.S. These funding sources could also be used in improving the employability of PWH to oversee programs designed for harm reduction, decriminalization of sex work, and comprehensive gender-diverse reproductive/sexual health education.

To uphold the integrity and dignity of the lives of PWH and communities vulnerable to HIV, recommendations have been made in the most recent report by HIV Justice Worldwide, *Molecular HIV Surveillance: A Global Review of Human Rights Implications*. In that report, the five main recommendations are:

- Take seriously and act upon community concerns about molecular HIV surveillance. Doing this with intentional compassion driven by the community can remove the medical mistrust and stigma that this tool has placed upon the shoulders of many advocates and activists in HIV.
- Respect the bodily autonomy and integrity of people with HIV in all our diversity.
- Molecular HIV surveillance implementers must demonstrate a clear public health benefit that outweighs the potential harms of MHS, including by ensuring protections. Demonstrated benefits of MHS must measurably include people with HIV.
- Providers ordering HIV sequencing must inform people with HIV about how their blood and data are being used for MHS purposes and be allowed to withdraw consent if they so wish, without fear of negative consequences to their HIV treatment and care.
- Implementers of MHS should publicly advocate against punitive or coercive laws and policies aimed at people with HIV and ensure that MHS is never used in criminal, civil, or immigration investigations or prosecutions.

While these strategies will be implemented differently across each state, one of the most effective is contracting skilled subject-matter experts with HIV to provide training and workshops for onboarding service providers (and refreshing long-standing employees) on the criminalization of HIV and protections to communities impacted by HIV. Implementers of MHS in various jurisdictions can spearhead and author position statements to advocate against the outdated laws and policies aimed at PWH. There are many ways to even the scales of justice in support of the communities working to reform the laws, but there must be a willingness to do so.

For HIV care providers, we urge you to explain to your patients how the tissue and blood collected will be used. It is vital to maintain trust with patients, and listening to concerns is part of that relationship.

These historical patterns of mistrust and data misuse can be corrected if the systems designing them and benefiting them are willing to examine the most innovative approaches developed by the communities impacted. After recommendations have been made from multiple networks of PWH and allies to update the new HIV plan, it’s time to see what integrity to health and accountability means in response to the concerns PWH have about their bodies, lives and safety. **HIV**



KAMARIA LAFFREY has been living with HIV since 2003 and currently serves nationally as the program director for HIV policy reform with Sero Project offering strategic planning and community mobilization training to state leaders living with HIV to change their HIV criminalization laws.



ANDREW SPIELDENNER, Ph.D., is the executive director of MPact: Global Action for Gay Health & Rights, associate professor of Health Communication at California State University-San Marcos, and a visiting scholar at Concordia University. Openly living with HIV, Dr. Spieldenner is a community-engaged researcher and advocate with over 25 years of experience in HIV.

HIV Care Tools

A pocket resource for HIV care providers

BY: NICOLÉ MANDEL

CLINICIANS can now access a new, free mobile app, HIV Care Tools, to help screen and care for people with or at risk for HIV. **HIV Care Tools** is a product of the Health Resources and Services Administration's AIDS Education and Training Center (AETC) Program and was developed under the federal Ending the HIV Epidemic (EHE) initiative.

HIV Care Tools is an up-to-date pocket resource for healthcare providers. It provides an alternative to paper guides, which often get lost, forgotten, or become dated. The information on the app is kept current with evidence-based and state-of-the-art care resources. The content is selected, reviewed, and updated by Susa Coffey, M.D., AETC National Coordinating Resource Center (NCRC) Medical Editor and Professor of Medicine in the Division of HIV, Infectious Diseases and Global Medicine at the University of California San Francisco, and John Nelson, Ph.D., CNS, CPNP, AETC NCRC Director and faculty at Rutgers University School of Nursing.

Mobile apps provide increased access to point-of-care tools for healthcare providers, which has been shown to support better clinical decision-making and improved patient outcomes.^{1,2,3}

"Our hope is to make providers more comfortable with HIV screening, prevention, and care, to expand the number of people who know their HIV status and are receiving high-quality care," said Dr. Coffey.

Content for the first phase of the app includes core reference materials, tools, and expert help that support principles of the EHE initiative's four pillars: diagnosis, treatment, prevention, and rapid response to outbreaks.

- **Quick guides** for HIV laboratory testing, non-occupational post-exposure prophylaxis (nPEP), pre-exposure prophylaxis (PrEP), the rapid start of antiretroviral therapy, sexual history taking, and resources to help patients pay for HIV medications.
- **Clinical calculators and screeners** for common co-occurring conditions ranging from behavioral health (depression, anxiety, PTSD, substance use) in the liver (FIB-4) and kidney function (CrCl). These were selected in partnership with the University of Washington's David Spach, M.D., the National HIV Curriculum editor-in-chief.

- **One-touch access to the National Clinician Consultation Center's (NCCC) warmlines** for clinical advice on HIV prevention and care, and management of substance use, hepatitis C, and COVID-19. The NCCC is a national center of the AETC Program.
- Clinician support through **AETC Program experts** offers free training and capacity-building assistance for the clinical care team.

Once the app is downloaded, all resources are fully functional off-line, without the internet. This assures broad access and is especially valuable in rural areas, prisons, and other settings with limited internet connection.

"We wanted to make sure we weren't leaving anyone behind," reflected Dr. Nelson. "The EHE is about making the extra effort to reach and support the clinicians providing HIV care in remote and resource-limited communities."

HIV Care Tools includes resources for both new and experienced HIV clinicians. The reference guides distill long and nuanced recommendations for busy clinicians who may be infrequent treaters. The calculators and screeners are mostly not HIV-specific and are helpful for any clinician. The tool is also useful for clinical education and to support health profession students, residents, and fellows. Future versions of the app will include more utilities to assist with antiretroviral (ARV) regimen selection.

The EHE initiative is a large, multi-agency effort to deploy existing knowledge and approaches in innovative ways. The AETC Program's role is in building HIV workforce capacity, including training. Through the EHE, AETC Program faculty and staff are working with non-traditional partners to ensure that all providers are comfortable

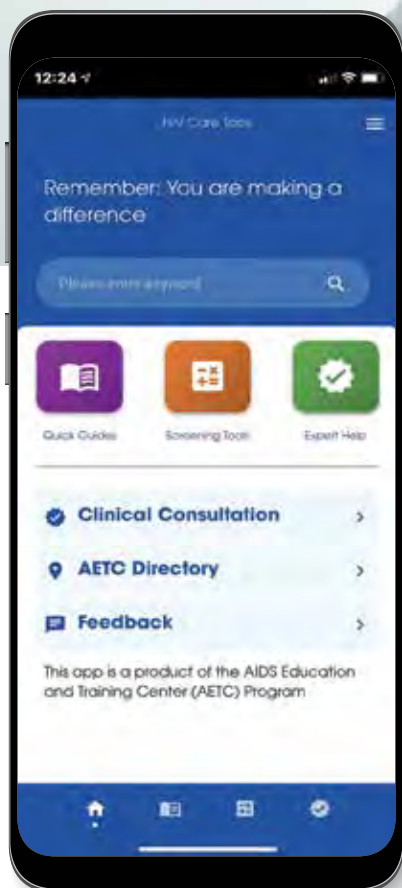
Visit <https://aidsetc.org/app> for more information about future updates and new features. Download **HIV Care Tools** in the App Store or Google Play:



<https://apps.apple.com/us/app/hiv-care-tools/id1551420790>



<https://play.google.com/store/apps/details?id=ucsf.aetc.app>



and competent in providing their clients with HIV prevention via PEP or PrEP, HIV diagnosis using the latest testing technologies, and state-of-the-art HIV care services. **HIV Care Tools** was developed to provide practical and convenient support for these providers.

Judith Collins, the AETC NCRC Marketing Manager sees a practical advantage: "Apps can be updated without the expenses of a new print run. We will continue to offer printable materials, but the HIV Care Tools app allows us the opportunity to provide clinical information through a dissemination channel that is becoming a standard for clinicians. We can reach more providers more efficiently." **HIV**



NICOLÉ MANDEL is the director of the Center for HIV Information at the University of California at San Francisco. She has more than twenty years of experience working in online publishing, and HIV care and prevention. She directs an experienced, multidisciplinary team of professionals in defining, implementing, and maintaining technology projects related to public health issues including HIV, viral hepatitis, and health disparities. Nicolé also manages the AETC NCRC website

REFERENCES

1. Aungst TD. Medical applications for pharmacists using mobile devices. *Ann Pharmacother*. 2013;47(7-8):1088-1095. [PubMed]
2. Mickan S, Tilson JK, Atherton H, et al. Evidence of effectiveness of health care professionals using handheld computers; a scoping review of systematic reviews. *J Med Internet Res*. 2013;15(10):e212. [PubMed]
3. Ventola CL. Mobile devices and apps for health care professionals: uses and benefits. *P T*. 2014;39(5):356-364. [PMC]

Jonathan S. Appelbaum, MD, FACP, AAHIVS Tallahassee, Florida

DR. APPELBAUM felt a “sense of duty.” Approximately 35 years ago the HIV epidemic was terrifying, claiming casualties at a staggering rate. In the early days of the epidemic, HIV was primarily a disease of young gay men; friends of Appelbaum’s and members of his community. This sense of duty to his community, a community in desperate need, motivated Appelbaum to pursue specializing in HIV care.

Appelbaum graduated from the University of Miami, School of Medicine and completed his Internal Medicine training at the University of Massachusetts Medical Center. He was a National Health Service Corp. scholarship recipient in medical school, and after residency he opened a practice in a medically underserved area in rural northeastern Connecticut. Appelbaum stayed in practice there for 12 years and then relocated to Fenway Community Health in Boston where he worked for 11 years, serving eight of those years as Fenway’s Medical Director. After that, Appelbaum was the Medical Director at Brigham and Women’s Physician Group before he relocated to Florida, where he practices today.

Appelbaum now teaches full time at Florida State University, College of Medicine where he is the Chair of the Department of Clinical Sciences. For nearly two years, Appelbaum has been doing clinical work at Care Point Health and Wellness, a clinic that supports the underserved in Tallahassee. He provides primary care, HIV care and LGBTQ+ care with a focus on the trans community. In addition to being credentialed as an HIV Specialist™ by AAHIVM, Appelbaum is board-certified in geriatrics.

For Appelbaum, the best part of caring for patients is the astounding advances in care for HIV-infected people over the past 28 years. The greatest obstacle is that, unfortunately, people are still becoming infected. “What I love about my current position is working with

“What I love about my current position is working with young, enthusiastic medical students and residents, our next generation of caregivers.”

young, enthusiastic medical students and residents, our next generation of caregivers,” says Appelbaum. “They inspire me to get up and come to work every day!”

An Academy member since the organization’s inception, he served for many years as the co-chair of the Academy’s National HIV & Aging Initiative and currently is the Chair of the National Board of Directors.

Appelbaum motivates his patients to adhere to their treatment regimens by providing patient-centered care, getting to know his patients as people, and through education. Looking to the future, Appelbaum envisions HIV will be “preventable by way of vaccine and curable in that we will have the ability to eradicate the viral genome from the host cell.” Until then, Appelbaum hopes to continue to help training the next generation of physicians; “the ones who will be caring for me in my old age!”



When he is not in practice, Appelbaum enjoys time at home; gardening, bicycling, and caring for his animals. When asked why he is an AAHIVM Member, Appelbaum says, “I joined the organization very early. I attended one of the early organizing meetings in Boston. I came onto the Board of Directors at the invitation of Scott Hitt, the founder of AAHIVM.” Appelbaum remains active with AAHIVM’s National Board of Directors; serving currently as the Chair of AAHIVM’s Florida Steering Committee and as the Co-chair of AAHIVM’s Executive Committee. **HIV**

ABOUT THE AUTHOR: AAHIVM Membership Director **AARON AUSTIN** organizes, engages and leads the Academy’s global membership of frontline HIV care providers around initiatives of advocacy, education and professional development. He is currently completing coursework for his MPH at The George Washington University Milken Institute School of Public Health.



UPDATE

CAROLYN CHU, MD, MSC, AAHIVS

Incoming AAHIVM Chief Medical Officer

FEATURED LITERATURE:

Girometti N, McCormack S, Tittle V, McOwan A, Whitlock G; 56 Dean Street Collaborative Group. Rising rates of recent PrEP exposure among MSM newly diagnosed with HIV: antiviral resistance patterns and treatment outcomes. AIDS. 2021 Dec 6. doi: 10.1097/QAD.0000000000003143. Online ahead of print.

With increased uptake and different medication options/dosing strategies for PrEP, it's important to gain further insight into cases of possible PrEP 'failure' as well as increased understanding of how PrEP can affect HIV testing results and subsequent best clinical practices. This study describes medical records review of individuals reporting recent PrEP exposure at HIV diagnosis, baseline testing, and clinical management at a high-volume comprehensive sexual health and HIV services program in the U.K. (review period: January 2016 to December 2020). Out of 1030 individuals (96% MSM) diagnosed with HIV, 52/1030 (5%) reported recent PrEP use. Over two-thirds were determined to have recently acquired HIV. Nineteen percent reported having switched between daily and event-based dosing at least once since last negative HIV result, although 69 percent were mostly taking daily PrEP at diagnosis. Possible reasons for PrEP 'failure' included suboptimal adherence, disruption of medication supply/access resulting in its discontinuation, and modification of PrEP use following relationship status changes (a reason for PrEP 'failure' could not be identified in 13 percent of individuals who reported excellent medication adherence). Individuals with recent PrEP exposure had significantly lower baseline HIV viral load. Genotype was successfully performed for 83 percent, and of these individuals, 30 percent had M184V/I (K65R was not observed). 48/52 attended a follow-up medical appointment [within two weeks] for ART initiation: all started a tenofovir-based NRTI backbone, and the third agent most commonly selected by providers was boosted darunavir, followed by bictegravir and dolutegravir. For 39 patients with 24-week follow-up information, all had achieved viral suppression.

AUTHOR'S COMMENTARY:

This study is a very timely one, as updated U.S. PrEP Clinical Practice Guidelines were released on December 8. PrEP remains highly efficacious, yet challenges regarding consistent and equal medication access, as well as low rates of PrEP persistence, remain—these are important areas for ongoing attention and advocacy. Additionally, authors note that “lower rates of viral DNA amplification and less information on resistance mutations ... represent a further challenge” for clinicians. In this study, the majority of patients underwent intensification to a 2-class ART combination which included one agent with a high genetic barrier to resistance; this approach did not affect subsequent adherence to ART or engagement into HIV care, and high rates of virologic suppression were observed at week 24.

FEATURED LITERATURE:

Yusuf HE, Knott-Grasso MA, Anderson J, et. al. Experience and outcomes of breastfed infants of women living with HIV in the United States: findings from a single-center breastfeeding support initiative. J Pediatric Infect Dis Soc. 2021 Dec 9; piab116. doi:10.1093/jpids/piab116. Online ahead of print.

This article describes ARV approaches to, and outcomes among, ten infants who were exclusively breastfed by nine mothers living with HIV and receiving care at a single U.S. urban health center. The center offered a multi-disciplinary support program to assist women with HIV who desired to breastfeed and met pre-established criteria (namely, adherence to care and ART, and sustained virologic suppression). Reasons for choosing to breastfeed included: concerns for infant health, disclosure concerns, cultural expectations, and religious beliefs. Eight women were non-native immigrants from low/middle-income countries in Africa, and four had previously delivered and nursed infants while living with HIV. Infants were initiated on a combination of zidovudine, lamivudine, and nevirapine for four to six weeks, followed by NVP alone continued through six weeks after breastfeeding discontinuation; mean duration of breastfeeding: 4.4 months. Mother-infant dyads were seen at monthly visits during which breastfeeding and ART adherence were assessed and supported, HIV PCR testing was pursued, and further counseling was provided e.g., guidance for weaning. Infant HIV RNA was measured at two to eight week intervals (depending on age, breastfeeding status, timing relative to NVP/breastfeeding cessation). All infants had negative viral RNA PCR measurements at a median age of sixteen months.

AUTHOR'S COMMENTARY:

This is the first U.S.-based report of breastfeeding outcomes of women living with HIV receiving comprehensive, multi-disciplinary care through a dedicated breastfeeding support program. Although participants may not be representative of the overall population of pregnant/parenting people with HIV in the U.S. (i.e., some women in this program had prior experience breastfeeding while living with HIV, and all were virologically suppressed on ARVs prior to conception or delivery), this program description and evaluation adds evidence to, and helps advance conversations around, the topic of breastfeeding and HIV in the U.S. Of note, no perinatal/postnatal transmissions were observed. Additional details such as infant clinical and laboratory monitoring practices and findings may also help address questions and/or concerns about optimal ARV prophylaxis approaches for breastfeeding infants.

FEATURED LITERATURE:

Klitenic SB, Levan ML, Van Pilsum Rasmussen SE, Durand CM. Science over stigma: lessons and future direction of HIV-to-HIV transplantation. *Curr Transplant Rep.* 2021 Nov 18; 1-10. doi: 10.1007/s40472-021-00345-y.

The HOPE (HIV Organ Policy Equity) Act, enacted November 2013, reversed a decades-long federal ban on use of organs from donors with HIV and authorized development and publication of criteria to re-search solid organ transplantation from donors with HIV to recipients with HIV (HIV D+/R+). This review describes HOPE Act implementation and progress to date, as well as ongoing systems- and community-related challenges and opportunities. As of July 2021, 46 out of 58 Organ Procurement Organizations have evaluated a HOPE donor (this increased from 16/58 in 2017). Thirty-five transplant centers in 21 states, many based in the eastern U.S., are approved to perform HIV D+/R+ transplants: 300 kidney and 87 liver transplants have occurred under approved research protocols. Early kidney transplant outcomes indicate 100% patient survival and 92% graft survival, and no differences in 1-year mean eGFR, HIV breakthrough, infectious hospitalizations, or opportunistic infections. Despite 16 states passing new legislation to facilitate HIV D+/R+ transplantation, authors identified policy restrictions in 34 states: this includes scenarios where state laws are “silent.” HIV-related stigma – including within the health care system—remains an area of concern and opportunity for increasing awareness and information sharing/education, as ongoing stigma may lead to less likely transplant referral/listing, affect PWH’s willingness to donate or accept organs, and may also impair deceased donor evaluation.

AUTHOR’S COMMENTARY:

Benefits of the HOPE Act include expansion of the organ donor pool, increased transplant access for PWH with end-stage organ disease, and decreased risk of waitlist mortality. Although several milestones have been reached in HOPE Act implementation, many challenges remain including uneven state restrictions and uptake as well as low numbers of potential donors. Additionally, the future possibility of HIV D+/R+ transplantation outside of research protocols remains to be determined. This review highlights the remarkable progress and achievements in the field of HIV-to-HIV transplantation medicine to date; authors also share a number of recommendations to further advance and help fully realize HOPE Act implementation and the promise it offers.

FEATURED LITERATURE:

Deschanvres C, Reynes J, Lamaury I, et. al; Dat’AIDS Study Group. Dolutegravir-based dual maintenance regimens combined with lamivudine/emtricitabine or rilpivirine: risk of virological failure in a real-life setting. *J Antimicrob Chemother.* 2021 Oct 15;dkab367. doi: 10.1093/jac/dkab367. PMID: 34651192.

In this observational study involving a multi-center French cohort, investigators evaluated virologic failures (VF) and resistance-associated mutations among participants switched to dolutegravir-based dual regimens. 1374 treatment-experienced participants were included: 58.2 percent switched to DTG/RPV and 41.8 percent to DTG/XTC. In the DTG/RPV group, duration of viral suppression at baseline was > 12 months in 93.7 percent (median 90 months); 43.8 percent had any history of VF. In the DTG/XTC group, duration of viral suppression at baseline was > 12 months in 92.8 percent (median 74.4 months); 19.8 percent had any history of VF. Adverse events leading to discontinuation—primarily CNS and gastrointestinal symptoms—occurred in ten percent and 8.2 percent of the DTG/RPV and DTG/XTC groups, respectively. Virologic failure was observed in 3.8 percent of DTG/RPV and 2.6 percent of DTG/XTC participants (median time to failure: 232 and 301 days). For participants with available genotypes at DTG/RPV failure, two harbored NNRTI RAMs detected on historical genotypes (E138A, L100I) whereas two harbored new RAMs (E138K, K101E, N155H). For participants with available genotypes at DTG/XTC failure, no new RAMs were detected and 1 genotype harbored a previously identified M184V. On multivariate analyses, history of an NNRTI-including regimen failure was associated with higher risk of VF among the DTG/RPV group; no factors associated with higher risk of VF were identified for the DTG/XTC group.

AUTHOR’S COMMENTARY:

Two-drug regimens of DTG/RPV and DTG/XTC effectively maintained virologic suppression in the large majority of treatment-experienced participants who underwent ARV switches and remained engaged in care in this ‘real world’ French cohort. Medications were well-tolerated overall, and rates of adverse events leading to medication discontinuation were comparable to previously reported rates from clinical trials. New resistance mutations were observed only in participants in the DTG/RPV group, although it should be noted that genotypes were unavailable for approximately half of all participants experiencing VF. Further, most participants had been virologically suppressed for years; this and other baseline characteristics of the cohort may limit the generalizability of these findings – especially for practices serving PWH with differing backgrounds. Nevertheless, results of this large observational analysis are encouraging regarding the durability of dolutegravir-containing dual therapy combinations.

SAVE THE DATE!

**Our Academy Council for Racial Equity
will be hosting its inaugural
Minority Student Open.**



WHEN

**Wednesday, March 30, 2022
12:00pm–2:30pm ET**

WHAT

The Minority Student Open is a virtual conference for medical, nursing, pharmacy, PA, and other health-related minority students and trainees. The free event features a plenary speaker, an interdisciplinary panel discussion and breakout sessions that will inspire and inform minority students and trainees to consider a health professions career in HIV care, policy or research.

WHO



Dr. M. Keith Rawlings, MD, Senior Medical Director, Medical Affairs at ViiV Healthcare, will be our Plenary Speaker. Prior to joining ViiV, Dr. Rawlings served as Director HIV Medical Sciences/ Gilead Sciences, Inc from 2011 to 2018. He oversaw the national field based team of Medical Scientists that provide medical education and training on HIV prevention and treatment. Other speakers and panelists will be announced soon!

WHY

Underrepresentation of people of color and members of minority communities in HIV prevention, treatment and research is a major problem confronting the US healthcare workforce. Our health system already confronts workforce shortages as many providers who cared for people at the dawn of the HIV pandemic had retired, or otherwise left practice, or are on the cusp of doing so. To strengthen human resources for health, representation of people of color and members of minority groups working as HIV specialist clinicians, practitioners and researchers is critically important. This Student Open will encourage the next generation of healthcare professionals to enter HIV prevention, care and research in their future practices.

**Contact Academy Membership Director Aaron Austin at
aaron@aaahivm.org to learn more about registration!**



STUDENT OPEN
HOSTED BY THE AMERICAN ACADEMY OF HIV MEDICINE'S
ACADEMY COUNCIL FOR RACIAL EQUITY