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NEWS ROUNDUP

Congress Reaches Agreement on Omnibus Spending Bill; Includes Boost for Medical Research

Congressional Republicans and Democrats have reached agreement on a $1.1 trillion omnibus spending bill that will fund most federal government operations through fiscal year (FY) 2017, which ends on 30 September. The product of lengthy negotiations, the [1,665-page bill](#) was made public on May 1 and was tentatively scheduled for a vote in the U.S. House of Representatives on May 3. The expected passage of the bill will end the threat of a government shutdown for the next five months. Although the omnibus bill covers all aspects of federal government spending, we will focus here on funding for medical research and for HIV prevention, opioid, and STD programs.

The omnibus bill’s funding levels for health agencies and programs stand in sharp contrast to the Trump administration’s [budget blueprint](#) for fiscal year 2018 (FY18), released in March. The National Institutes of Health (NIH) will get a $2 billion funding increase for the remainder of FY17, rather than a $1.2 billion decrease proposed by the Trump administration. Although the omnibus bill does not address funding for FY18, it now appears highly unlikely that Congress will back Trump’s proposal to make deep cuts totaling $5.8 billion to the NIH budget for FY18.

The FY17 omnibus bill’s $2 billion funding boost for NIH includes the following funding increases:

- $650 million (430%) to fight opioid abuse; the total of about $800 million for opioid addiction programs will be divided among the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration;
- $476 million for the National Cancer Institute;
- $400 million for Alzheimer’s disease research;
- $120 million for the Precision Medicine Initiative, which is collecting and analyzing genetic and health data to accelerate research and improve health;
- $110 million for the BRAIN Initiative designed to increase understanding of the human brain; and
- $50 million for research to combat antibiotic-resistant bacteria.

In addition, the FY17 omnibus spending bill does not cut or prohibit federal funding for Planned Parenthood. The Federal AIDS Policy Project also noted that, under the bill, CDC’s HIV prevention efforts in schools would be level-funded at $33.1 million. The Office of Adolescent Health’s Teen Pregnancy Prevention Program (TPPP) would likewise be level-funded at $101 million.

However, FY17 funding for sexually transmitted disease (STD) programs is cut $5 million in the omnibus spending bill – despite recent increases in U.S. STD cases, particularly for syphilis. “At a time of a 20-year high in STDs in the United States, this funding cut is devastating,” commented David Harvey, executive director of the National Coalition of STD Directors. “Federal STD funding has not been increased since 2003. Due to inflation and small cuts, this translates into a 38% reduction in purchasing power in 14 years.”

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U.S. House Weighs Changes to American Health Care Act; Health Groups Remain Opposed

Under pressure from the Trump Administration, Republicans in the U.S. House of Representatives...
resumed negotiations on the American Health Care Act (AHCA) – a Republican proposal to repeal and replace the Patient Protection and Affordable Care Act (commonly referred to as Obamacare). The previous version of AHCA had been introduced on March 6 and subsequently amended to garner support from different factions within the Republican party before a planned vote in late March. However, on March 24, U.S. House speaker Paul Ryan and President Donald Trump withdrew the AHCA from consideration when it became clear the legislation lacked the votes needed for passage. A group of conservative Republican representatives known as the Freedom Caucus were particularly vocal in their opposition to the original bill, arguing that it did not go far enough to repeal provisions of Obamacare that the caucus found unacceptable. (For more details about the AHCA and its provisions, please see the article, The American Health Care Act: Main Features and Congressional Debate in last month’s issue.)

At the urging of the Trump administration, representatives of the Freedom Caucus and House Republican moderates known as the Tuesday Group met to negotiate changes to AHCA that would win support of enough Republican legislators for passage in the U.S. House. By late April, the negotiators reached agreement on the so-called MacArthur amendment to the AHCA, named after New Jersey Congressman Tom MacArthur, who was involved in drafting the amendment. The MacArthur amendment would allow states to seek permission from the federal government to develop their own list of essential health benefits (EHBs) – basic health benefits that must be provided by all marketplace health insurance plans – rather than adhering to the list of 10 EHBs specified in Obamacare. States could also allow insurers to charge higher premiums to persons with pre-existing health conditions, provided that insurers make a high-risk pool available to those patients. In addition, states could seek waivers that would allow insurers to charge older persons even higher insurance premiums than were allowed under Obamacare or the original version of the AHCA. Obamacare requires that the oldest consumers be charged no more than 3 times the premiums of younger consumers for the same coverage. The original version of AHCA increased this limit to 5 times higher, and the MacArthur amendment would allow states to seek even higher premium ratios for older persons.

Under the provisions of the MacArthur amendment, states could seek waivers provided that their proposed insurance changes either:

- reduce average premiums for health insurance coverage in the state;
- increase insurance enrollment;
- stabilize the market for insurance coverage;
- stabilize premiums for people with pre-existing coverage; or
- increase the choice of health plans in the state.

A summary and analysis of the MacArthur amendment’s provisions are available here and here. In addition, the Kaiser Family Foundation has produced an extensive summary of the entire AHCA as amended, including descriptions of all major changes relative to Obamacare. The House Freedom Caucus issued a statement supporting the bill claiming, “The MacArthur amendment will grant states the ability to repeal cost-driving aspects of Obamacare left in place under the original AHCA. While the revised version still does not fully repeal Obamacare, we are prepared to support it to keep our promise to the American people to lower healthcare costs. We look forward to working with our Senate colleagues to improve the bill. Our work will continue until we fully repeal Obamacare.”
The Freedom Caucus’s endorsement of the MacArthur amendment placed pressure on moderate Republicans to back the revised AHCA, which would ensure House passage of the bill even without any votes from House Democrats. However, as of this writing, it is unclear whether the updated AHCA has sufficient support for passage. During the Congressional recess in April, many Republican representatives faced concerned constituents who expressed their support for Obamacare and its key provisions. These include Obamacare’s very popular provisions mandating coverage for EHBS and pre-existing conditions, which states could opt out of under AHCA as modified by the MacArthur amendment. The latest version of AHCA also retains controversial provisions of the original legislation that would limit Medicaid enrollment and spending and insurance subsidies – provisions, among others, that the Congressional Budget Office had projected would increase the number of insured Americans 24 million by 2026.

Reactions to AHCA as Modified by the MacArthur Amendment
As was the case with earlier versions of AHCA, many patient and aging advocacy groups, public health, and medical professional organizations are strongly opposed to the AHCA as modified by MacArthur amendment. A sampling of extracts from letters to Congress and official statements are included below:

**Federal AIDS Policy Project (FAPP):** On May 1, FAPP sent a letter to U.S. House members urging them to oppose the latest version of AHCA. The letter, which was signed by 77 organizations that provide services or advocacy for people living with HIV and LGBT communities, states: “The AHCA and the proposed amendment would return us to a time when healthcare coverage was out of reach for too many people with HIV. Our serious concerns with the initial bill outlined in a March 22nd letter have significantly worsened. Allowing states to opt out of essential health benefits and to waive community rating for individuals with pre-existing conditions would once again make healthcare coverage unaffordable and inadequate for most people with HIV . . . We cannot afford to go back to the pre-ACA [Affordable Care Act] sick care system that focused on treating disability and disease rather than preventing it.”

**AIDS United:** “The amended bill retains the devastating provisions of the original, which would cause 24 million people to lose health coverage over ten years, drastically restructure Medicaid to end it being an entitlement program, reduce funding for Medicaid by $800 billion over 10 years, and use much of the savings to give tax cuts to wealthy individuals and families,” according to AIDS United. “The McArthur amendment ostensibly continues to protect people with pre-existing conditions from being denied health coverage and continues the federal standard for essential health benefits. These protections in the amendment are wafer thin, however, because the amendment allows states to apply for a waiver that would make it easier for insurance companies to raise rates on people living with HIV, people with other chronic conditions, and older adults. The proposed solutions include high-risk pools, which repeatedly have failed people living with HIV and other chronic conditions. Coverage in high-risk pools often has excessively high premiums, deductibles, and co-pays along with limitations on needed drug coverage and care. Under the amendment, states also could apply for a waiver that would allow insurers to offer plans that exclude coverage for essential health benefits such as maternity coverage, prescription drugs, or mental health treatment.”

**American Public Health Association (APHA):** “The American Health Care Act is bad policy,” according to Georges Benjamin, executive director of APHA. “The measure would force millions to lose insurance, cut key public health investments, and gut health protections for Americans. Now, in a bid to win votes,
they’ve taken a bad bill and made it worse.” In particular, the APHA criticized MacArthur amendment changes that would allow states to opt out of requiring that health plans cover the EHBs, allow insurers to charge people higher premiums based on pre-existing conditions, and increase out-of-pocket costs for older adults.

**American Medical Association:** “As we have previously stated, we are deeply concerned that the AHCA would result in millions of Americans losing their current health insurance coverage. Nothing in the MacArthur amendment remedies the shortcomings of the underlying bill. The amendment does not offer a clear long-term framework for stabilizing and strengthening the individual health insurance market to ensure that low and moderate income patients are able to secure affordable and adequate coverage, nor does it ensure that Medicaid and other critical safety net programs are maintained and adequately funded. The MacArthur amendment would allow states to apply for waivers from critical consumer protections provided in the Affordable Care Act, including the age rating ratio of 3 to 1, the requirements that health insurers must cover certain essential health benefits, and the ban on health status underwriting. The current ban on health status underwriting protects individuals from being discriminated against by virtue of their medical conditions . . . Although the MacArthur amendment states that the ban on pre-existing conditions remains intact, this assurance may be illusory as health status underwriting could effectively make coverage completely unaffordable to people with pre-existing conditions. There is also no certainty that the requirement for states to have some kind of reinsurance or high-risk pool mechanism to help such individuals will be sufficient to provide for affordable health insurance or prevent discrimination against individuals with certain high-cost medical conditions.”

**American Hospital Association:** “Our top concern is what this change [the MacArthur amendment] could mean for older and sicker patients, including those with pre-existing conditions, such as cancer patients and those with chronic conditions,” commented American Hospital Association president and CEO Rick Pollack. “The amendment proposed this week would dramatically worsen the bill. The changes included put consumer protections at greater risk by allowing states to waive the essential health benefit standards, which could leave patients without access to critical health services and increase out-of-pocket spending. This could allow plans to set premium prices based on individual risk for some consumers, which could significantly raise costs for those with pre-existing conditions . . . As the backbone of America’s health safety-net, hospitals and health systems must protect access to care for those who need it and ensure that the most vulnerable patients are not left behind. The AHCA continues to fall far short of that goal.”

**America’s Essential Hospitals:** “This latest version of the AHCA is not an improvement. It’s simply bad policy that will cut a lifeline of health care for millions of Americans. The legislation also would leave unchanged more than $800 billion in Medicaid cuts over the next decade, breaking the nation’s safety net and saddling states, local governments, and taxpayers with new costs for indigent care.”

**American Association of Retired Persons (AARP):** “This harmful legislation still puts an age tax on older Americans and puts vulnerable populations at risk through a series of backdoor deals that attempts to shift responsibility to states. Older Americans need affordable health care services and prescriptions. This legislation still goes in the opposite direction, increasing insurance premiums for older Americans and not doing anything to lower drug costs,” according to AARP executive vice president Nancy LeaMond. “Specifically, we are concerned that the American Health Care Act will weaken the fiscal
sustainability of Medicare; dramatically increase premium and out-of-pocket costs for 50 to 64 year-olds purchasing coverage on the individual insurance market; substantially increase the number of Americans without insurance; and put at risk millions of children and adults with disabilities and poor seniors who depend on the Medicaid program to access long-term services and supports and other benefits.” In addition, the MacArthur amendment “would allow states to waive important consumer protections – such as allowing insurance companies to once again charge Americans with pre-existing conditions more because they’ve had cancer, diabetes, or heart disease – would make this bad bill even worse.” AARP’s Public Policy Institute projects that, if the amended version of the AHCA becomes law, the health insurance premiums for people with pre-existing conditions who had to buy individual health insurance coverage through a high-risk pool could exceed $25,000 per year in 2019.

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National Academies Report Outlines Strategies for Eliminating Hepatitis B and C in the U.S.

Adopting a comprehensive strategy to substantially increase diagnosis rates for hepatitis B (HBV) and hepatitis C (HCV) and promote linkage to and retention in care could prevent an estimated 90,000 hepatitis-related deaths in the U.S. during the next 15 years, according to A National Strategy for the Elimination of Hepatitis B and C: Phase Two Report, from the National Academies of Science, Engineering, and Medicine (NAS). For their report, NAS researchers developed models comparing different levels of diagnosis, care, and treatment for both HBV and HCV. They found that, to reduce HBV deaths 50% by 2030 (relative to a 2015 baseline) would require diagnosing 90% of people living with HBV, bringing 90% of those diagnosed into care, and treating 80% of those for whom treatment is indicated. Meeting these HBV targets would prevent more than 60,000 deaths and reduce new cases of hepatocellular carcinoma by 45%. For HCV, a strategy that combines aggressive case finding with unrestricted HCV treatment would decrease deaths from chronic HCV infection nearly two-thirds and reduce new HCV infections 90% by 2030, compared to 2015.

“Meeting these targets depends on considerable improvements in testing, diagnosis, and care, as well as increased preventive measures and focused research,” according to the report. “This program will require the cooperation of various federal and state government agencies, as well as professional societies, legislators, and private sector organizations.” To help ensure success, NAS recommends that the U.S. federal government designate a central office to coordinate efforts to eliminate HBV and HCV. The report includes additional recommendations focusing on: viral hepatitis surveillance; interventions for prevention, testing, care, and treatment; service delivery; and funding viral hepatitis programs and activities.

These recommendations include the following:

- CDC, in partnership with state and local health departments, should support standard hepatitis case finding measures and the follow-up and monitoring of all viral hepatitis cases reported through public health surveillance.
- CDC should support cross-sectional and cohort studies to measure HBV and HCV infection incidence and prevalence in high-risk populations.
- States should expand access to adult HBV vaccination, removing barriers to free immunization in pharmacies and other easily accessible settings.
- CDC and medical organizations should recommend testing designed to prevent mother-to-child transmission of HBV.
• States and federal agencies should expand access to syringe exchange and opioid agonist therapy in accessible venues.
• CDC should work with states to identify settings appropriate for enhanced viral hepatitis testing based on expected prevalence.
• Public and private health insurance plans should remove restrictions that are not medically indicated and offer direct-acting antivirals to all patients with chronic hepatitis C.
• The National Committee for Quality Assurance should establish measures to monitor compliance with viral hepatitis screening guidelines and HBV vaccine birth dose coverage.
• Liver and infectious disease organizations should partner with primary care providers and their professional organizations to build capacity to treat HBV and HCV in primary care.
• The Department of Health and Human Services (HHS) should work with states to build a comprehensive system of care and support for special populations with HBV and HCV on the scale of the Ryan White system.
• The criminal justice system should screen, vaccinate, and treat HBV and HCV in correctional facilities according to national clinical practice guidelines.

In addition, the NAS researchers recommend that the federal government should purchase the rights to a direct-acting antiviral for use in neglected market segments, such as Medicaid, the Indian Health Service, and prisons. They estimate that acquiring these licensing rights would cost about $2 billion, after which states would pay about $140 million to treat 700,000 Medicaid beneficiaries and prisoners (an average of about $3,000 per person treated). In contrast, following the status quo for providing treatment in these underserved groups would cost about $10 billion over the next 12 years and treat only 240,000 Medicare beneficiaries and prisons (an average of more than $40,000 per person treated).

New York Launches Hepatitis C Elimination Campaign
New York state recently launched its Hepatitis C Elimination campaign and an associated website. The campaign is a statewide collaboration that includes policy-makers, healthcare and social service providers, and persons living with HCV and their advocates. The campaign to eliminate HCV in New York is based on the following five pillars:
• Enhance HCV prevention, testing, and linkage to care services for people who inject drugs, people who are incarcerated, men who have sex with men, and other populations disproportionately impacted by HCV infection.
• Expand HCV screening and testing to identify people living with HCV who are unaware of their status and link them to care.
• Provide access to clinically appropriate medical care and affordable HCV treatment without restrictions, and ensure the availability of necessary supportive services for all New Yorkers living with HCV infection.
• Enhance New York state (NYS) HCV surveillance, set and track HCV elimination targets, and make this information available to the public.
• Commit NYS government and elected officials, public health professionals, HCV experts, and industry partners to leadership and ownership of the NYS Plan to Eliminate HCV alongside community members living with and affected by HCV.
As of late April, more than 130 stakeholder groups had endorsed a consensus statement calling for HCV elimination in the state. “Despite the availability of effective, all-oral treatments to HCV, and despite the public health and harm reduction tools available to prevent new infections, HCV now kills more people in this country than any other infectious disease; this includes the combined deaths of HIV, pneumococcal disease, tuberculosis, and 57 other infectious diseases,” according to the HCV elimination campaign website. “Given the availability of new highly effective, well-tolerated, curative treatments, we can no longer settle for a low cure rate that perpetuates the high fiscal and human costs of inaction.

UNAIDS Urges Action to Stop Rising HIV Infections Among Persons Who Inject Drugs

In a recent statement to the U.N. Commission on Narcotic Drugs, UNAIDS focused attention on the recent spike in HIV infections among people who inject drugs (PWID) globally and called for urgent action to prevent new infections and safeguard the health of PWID. Despite the adoption in 2011 of a global target to reduce HIV incidence 50% among PWID by 2015, new infections in this population actually increased 33% globally during the period, from about 114,000 to 152,000 annually. According to UNAIDS:

- Of the approximately 12 million persons who currently inject drugs worldwide, an estimated 1.6 million are living with HIV and 10 million are living with hepatitis C (HCV).
- PWID are often marginalized and lack access to essential health services. For example, of 158 countries where injection drug use is reported, nearly half (78) do not offer opioid substitution therapy and more than a third (68) still do not provide needle and syringe programs.
- Between 2010 and 2014, only one-thirtieth (3.3%) of HIV prevention funds went to programs for PWID.

To substantially reduce HIV infections among PWID, UNAIDS is urging nations to increase their investment in HIV prevention programs for this key population more than 10-fold to $1.5 billion by 2020. An investment of this magnitude would be sufficient to provide HIV prevention and harm reduction services to 90% of PWID worldwide.

“UNAIDS supports people-centered, public health approaches to reduce HIV and other vulnerabilities among people who inject drugs,” according to the statement. “A comprehensive package of interventions, including needle and syringe programs and opioid substitution therapy, provided in a legal and policy environment that enables access to services, prevents infection, and reduces deaths from AIDS-related illnesses, TB, viral hepatitis and STIs.” Some studies have shown that, if methadone maintenance therapy were widely available, 130,000 new HIV infections could be prevented outside sub-Saharan Africa each year – a major step forward toward ending the AIDS pandemic.

Fair Pricing Coalition Proposes Roadmap to Control Drug Costs

Spending on drugs and biologics has been increasing rapidly in the U.S., rising 8.5% during 2015 to $310 billion. Record high prices for medications are straining government and household budgets alike. In a 2015 survey, about one in four Americans said that prescription medicines were difficult for them to afford, and a similar number reported that they or a family member had not filled a prescription or had
cut pills in half or skipped doses due to high drug costs. “There is increasing bipartisan support for cost controls and a groundswell of consumer-based advocacy for novel, forward-thinking regulations,” according to the Fair Pricing Coalition (FPC) – a group of policy leaders and advocates working to ensure affordable access to drugs for HIV and viral hepatitis. “While radical ideas abound, prices can be dramatically lowered through tailored adjustments to existing regulatory programs.” In their recent report, Tackling Drug Costs, the FPC provides a roadmap for the Trump Administration and the 115th Congress “to promptly modernize and strengthen existing regulations and statutes for controlling drug costs, drawing on existing authority and concrete legislative actions.”

FPC’s roadmap proposes four main approaches for controlling drug costs:
- Fixing price formulas – by modernizing and strengthening current ceiling price formulas to ensure that government payers do not pay more for drugs than commercial payers.
- Enhancing existing penalties for excessive prices – by removing inflation penalty caps, increasing penalties for drugs with excessive price hikes, and applying penalties to new drugs whose launch prices far exceed those of top sellers in the same drug class.
- Pooling purchasing power – by increasing inter- and intra-agency collaboration to consolidate federal and state negotiating power over drug prices.
- “Pulling back the curtain” – by increasing transparency concerning the costs for drug development, marketing, and executive compensation costs and the effects these have on drug pricing.

“Together, these proposals direct a clear path to reduce drug prices, leveraging existing tools to modernize a broken system,” according to FPC. “The Administration must move swiftly and decisively – the American people, including taxpayers and those facing an increasing number of barriers to life-saving prescription drugs, demand action.”

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Homeless U.S. Veterans Have High Rates of HIV and Viral Hepatitis
U.S. military veterans are disproportionately affected by HIV and chronic hepatitis C (HCV) and hepatitis B (HBV) infection. In addition, homeless veterans are at particularly high risk for HIV, HCV, and HBV infection as a result of overlapping risk factors that include high rates of mental health disorders and substance use disorders. However, only limited information has been available on the prevalence of HIV and viral hepatitis among homeless veterans nationally. To address this gap, researchers from the Department of Veterans Affairs (VA) analyzed data from the VA health system on HIV, HCV, and HBV testing, infection confirmation rates, and diagnoses among both non-homeless veterans and veterans who used homeless services during 2015.

In this study, the approximately 243,000 veterans who had made one or more visits to a VA homelessness service center were considered homeless, and the remaining more than 5.4 million veterans were considered non-homeless. Among the homeless veterans in VA care in 2015, about 64% were tested for HIV, 78% were tested for HCV, and 53% were tested for HBV. The prevalence of HIV infection among homeless veterans was more than three times higher (1.52% versus 0.44%) than among non-homeless veterans. The VA researchers found similar disparities in the prevalence rates for viral hepatitis among homeless versus non-homeless veterans: rates were 4.5 times higher (12.1% versus 2.7%) for HCV and 2.5 times higher (0.99% versus 0.44%) for HBV.
The study authors note that the high prevalence of HIV and viral hepatitis among homeless veterans indicate that integrated healthcare delivery should be linked with homeless services. “While homeless veterans face competing priorities including housing, comorbid medical conditions, and a myriad of social barriers to maximizing their health, these data suggest that comprehensive, wrap-around services for homeless veterans combined with treatment of HIV and HCV for co-infected individuals might be necessary to address these major determinants of health simultaneously,” according to the authors. “The unique structure of VA allows for the integration of healthcare delivery with homeless services to better meet the needs of homeless veterans living with HIV, HCV, and HBV moving forward.”

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OTHER NEWS REPORTS AND MATERIALS

CDC Awards $11 Million in First-Year Funding for New High-Impact Prevention Projects
During April, the CDC awarded approximately $11 million in first-year funding to 30 community-based organizations (CBOs) to implement comprehensive HIV prevention programs for young men of color who have sex with men, young transgender people of color, and their partners. Of the 30 funded organizations, 23 will primarily target young men who have sex with men of color and their partners, and 7 will target young transgender persons of color and their partners. Each funded CBO will receive about $360,000 per year over a 5-year period for high-impact prevention programs designed to reduce new HIV infections, increase access to care, and promote health equity by:

- increasing HIV testing and linking those who test positive to HIV medical care;
- increasing referrals to partner services; and
- providing prevention and essential support services for people living with HIV and those at high risk of becoming infected.

“Recent scientific advances have given us powerful new strategies to stop HIV, including improved testing techniques, early treatment with antiretroviral medications, and pre-exposure prophylaxis,” noted Eugene McCray, the director of CDC’s Division of HIV/AIDS Prevention, in a letter announcing the awards. “This new funding program will help accelerate efforts to deliver these advances to the people who need them most.”

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FDA Approves Use of HCV Meds Sovaldi and Harvoni for Pediatric Patients
During April, the U.S. Food and Drug Administration (FDA) announced that Sovaldi (sofosbuvir) and Harvoni (ledipasvir and sofosbuvir) – medications previously approved for the treatment of chronic hepatitis C virus (HCV) infection in adults – may now also be prescribed for children and adolescents 12 to 17 years old. According to FDA, Sovaldi and Harvoni are the first direct-acting antivirals (DAAs) that have been approved for children and adolescents with HCV. Unlike early HCV drugs, DAAs reduce the amount of HCV in the body by directly interfering with viral replication. In most cases, DAAs can cure HCV infection within a few months. Children born to HCV-positive women may become infected with the virus. An estimated 23,000 to 46,000 children in the U.S. are living with HCV infection. “These approvals will help change the landscape for HCV treatment by addressing an unmet need in children
and adolescents,” noted Edward Cox of FDA’s Center for Drug Evaluation and Research. Under the terms of the drug approvals, Sovaldi and Harvoni provide treatment options for all six major genotypes of HCV among children 12 years or older weighing at least 35 kilograms (77 pounds).

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Report Highlights Global Social Work Response to HIV

“Social workers in all parts of the world have been responding to the unique challenges of HIV since the earliest days of the epidemic. HIV was, and remains, a social challenge as much as a biomedical challenge,” according to Getting to Zero: Global Social Work Responds to HIV, by the International Association of Schools of Social Work and UNAIDS. The 438-page report presents detailed information about HIV-related social work interventions that have succeeded in a range of geographic and cultural settings worldwide. The book arranges most of these interventions into three themes – zero new HIV infections, zero discrimination, and zero AIDS-related deaths – that correspond to the “getting-to-zero” goals that are the framework for the global HIV/AIDS response and for many programs on the national, state, and local levels. A fourth section of the book focuses on the role of social work policy and professional development in national and regional HIV/AIDS initiatives. In the book’s foreword, UNAIDS executive director Michel Sidibé notes, “This is more than a compilation of scientific articles on the response to HIV by social workers. It is also a collection of stories told with candor about restoring hope, dignity, and social capital to people and their families in order that they can withstand the shocks they encounter in life. It is about the experiences of people who are vulnerable to HIV and their caregivers, showing us that it is possible to live free from inequality and discrimination. And it is about enabling people living with HIV to live healthy and fulfilled lives.”

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HHS Updates Treatment Guidelines for Opportunistic Infections & HIV Treatment in Children

The U.S. Department of Health and Human Services (HHS) recently updated its Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents and its Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. The revised opportunistic infection guidelines incorporate new recommendations regarding the concurrent use of HIV antiretroviral drugs and medications used for opportunistic infections (OIs). In particular, there is updated guidance about the use of anti-malarial and anti-HCV drugs in persons receiving HIV treatment, including information about potential side effects. The guideline’s section on malaria has also been revised to include recent statistics on the epidemiology and treatment of malaria and potential drug interactions between anti-malarial drugs and other medications, including antibiotics, antifungals, and direct-acting antiviral drugs prescribed for HCV infection.

The pediatric guidelines for HIV treatment include changes to the preferred antiretroviral (ARV) regimens for children starting ARV treatment, based on recent data on drug efficacy, administration, and toxicity. The updated guidelines also include the use of body weight as a consideration in the selection of ARVs for children: “Although age can be used as a rough guide, body weight is the preferred determinant of the recommendation for selecting a specific drug, when available, except for infants less than 14 days of age.” They also include new guidance on monitoring adherence to ARV treatment and changing treatment regimens in children. In addition, the guidelines clarify recommendations for diagnostic testing of infants at higher risk of perinatal HIV transmission and those who have received multidrug antiretroviral prophylaxis.

Read current and back issues of the HIV and Hepatitis Health Disparities Update online at aac.org/HDupdate.
NASTAD Membership Expands to Include Cities and Counties
The National Alliance of State and Territorial Directors (NASTAD) recently updated its bylaws to allow CDC-funded local jurisdictions – including cities and counties – to become members and join in the organization’s efforts to end the epidemics of HIV, viral hepatitis, and related health conditions. The local jurisdictions of Baltimore, Chicago, Los Angeles County, Houston, New York City, Philadelphia, and San Francisco are the first to have joined NASTAD. “The addition of these new members will foster stronger collaboration between health departments with long histories of working on urban epidemics – which will provide opportunities for peer-to-peer exchange and unify local and state efforts to end the HIV and hepatitis epidemics,” according to NASTAD. Calling the expansion of NASTAD “a huge step forward,” the organization’s executive director Murray Penner noted, “The end of the HIV and hepatitis epidemics is for the first time within our reach, and it’s hard to overstate the value of welcoming large urban jurisdictions into our membership. States and cities have learned a lot of lessons over the years about how to combat the HIV and hepatitis epidemics. By coming together, we will exponentially increase our effectiveness.” NASTAD board chair DeAnn Gruber further stated that, “By working more collaboratively with local jurisdictions, NASTAD members can continue to take the necessary steps to develop and support programs and policies that prevent new infections, ensure swift linkage to care, and provide access to affordable, high-quality care for people living with HIV and hepatitis.”

NLM’s AIDSource Collection Is Now Also Available in Spanish
The National Library of Medicine (NLM) recently launched a Spanish-language version of AIDSource, its curated collection of HIV/AIDS-related materials from government, academic, and other sources. The site links to fact sheets, reports, timelines, glossaries, and lists of organizations and service providers organized into the following topic areas:

- basic HIV/AIDS information;
- HIV prevention;
- HIV treatment;
- HIV-related conditions;
- HIV/AIDS policies and organizational programs;
- living with HIV/AIDS
- medical practice guidelines
- mobile resources;
- multimedia
- news resources;
- research;
- special populations;
- statistics and surveillance;
- training resources;
- HIV navigation resources; and
- PrEP navigation resources.

Both the English and Spanish sites also incorporate easy-to-use search features, as well as access to two
widgets on HIV/AIDS Awareness Days and STD testing services. NLM encourages users to provide feedback on the AIDSource site by emailing: tehip@teh.nlm.nih.gov.

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Recent Webinars on Housing and HIV Health Outcomes & HIV and Hepatitis Prevention in Rural Communities

The National Center for Innovation in HIV Care has posted materials from its recent webinar, Housing and HIV Health Outcomes, which was held on April 5. Presenters in the hour-long webinar discuss examples of housing investments that are designed to improve health outcomes for people living with HIV, reduce transmission, reduce HIV-related health disparities, and make progress toward ending the AIDS epidemic. The webinar page also includes links to presentation slides and a variety of other materials related to housing status, medical care, and health outcomes among persons living with HIV.

The HIV Prevention Justice Alliance and the Treatment Action Group have posted the video and slide set from their March 20 webinar, Injection Drug Use and Comprehensive HIV and Hepatitis C Prevention in Rural U.S. Communities. The 90-minute presentation included the perspectives of state and local leaders on the response to the 2015 HIV and HCV outbreak in southern Indiana, as well as discussions of national trends in syringe access for persons who inject drugs (PWID), community-driven harm reduction approaches to prevent HIV transmission among PWID, and the role of public health and policy in addressing injection drug use and infectious disease transmission in rural U.S. communities.

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New Fact Sheets and Other Resources from CDC, AIDSInfo, and HCV Advocate

In time for National Youth HIV/AIDS Awareness Day (April 10) and National Transgender HIV Testing Day (April 18), CDC posted updated versions of two fact sheets – HIV Among Transgender People and HIV Among Youth – as well as the slide set Pediatric HIV Surveillance (through 2015). CDC also updated the fact sheet HIV in the United States by Geographic Distribution, which provides state and regional (Northeast, Midwest, South, and West) breakdowns of HIV diagnoses, lifetime infection risk, and the numbers of people living with HIV or AIDS.

AIDSInfo has produced new versions, in English and Spanish, of the following consumer-oriented fact sheets on HIV care and treatment:

- HIV Treatment: The Basics (Spanish)
- Just Diagnosed: Next Steps After Testing Positive for HIV (Spanish)
- When to Start Antiretroviral Therapy (Spanish)
- What to Start: Choosing an HIV Regimen (Spanish)
- FDA-Approved HIV Medicines (Spanish)
- Drug Resistance (Spanish)
- HIV Medication Adherence (Spanish)
- Following an HIV Regimen: Steps to Take Before and After Starting HIV Medicines (Spanish)
- HIV and Immunizations (Spanish)
- What Is a Drug Interaction? (Spanish)

The HCV Advocate and Hepatitis C Support Project have also recently developed several new and
updated fact sheets on hepatitis C and harm reduction. These materials include:

- **HCV & Harm Reduction Abscess**
- **HCV & Harm Reduction: Overdose**
- **HCV & Harm Reduction: Cotton Fever**
- **Easy C Fact Sheet: Methadone and HCV Treatment**

The Hepatitis C Support Project has also published *A Guide to Understanding Hepatitis C 2017*, an 18-page resource with information about HCV transmission, progression, symptoms, diagnosis, treatment options, treatment considerations, and disease management. In addition, the guide includes contact information for Patient Assistance Programs, a glossary of hepatitis terms, and resources for more detailed information about HCV.

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FEATURED HEALTH RESOURCES

**Materials for National Asian and Pacific Islander HIV/AIDS Awareness Day (May 19)**

The 13th annual National Asian and Pacific Islander HIV/AIDS Awareness Day will be held on Friday, May 19. The theme for the day is “Saving face can’t make you safe. Talk about HIV for me, for you, for everyone.” The lead agency for this Awareness Day is The Banyan Tree Project – a national campaign to end the silence and shame surrounding HIV/AIDS in Asian and Pacific Islander communities. To help commemorate the day, we’ve compiled an annotated list of online resources focusing on HIV/AIDS among Asians and Pacific Islanders.

- **National Asian and Pacific Islander HIV/AIDS Awareness Day.** AIDS.gov web page with links to information and resources about HIV/AIDS in this community.
- **HIV/AIDS and Native Hawaiians/Other Pacific Islanders** and **HIV/AIDS and Asian Americans.** Web pages from the Office of Minority Health with detailed statistical information about HIV testing, HIV and AIDS cases, and death rates among Native Hawaiians and other Pacific Islanders.
- **HIV Infections Among Asians.** CDC fact sheet with recent HIV/AIDS statistics, plus information on risk factors and barriers to prevention among Asians living in the U.S. and dependent areas, and steps CDC is taking to address HIV/AIDS in this population group.
- **HIV Among Native Hawaiians and Other Pacific Islanders in the United States.** CDC fact sheet covering the same range of topics in the two fact sheets directly above, except that the focus is on Native Hawaiians and other Pacific Islanders.
- **Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2015.** This CDC report includes information about HIV and AIDS cases among Asian and Pacific Islanders and other racial/ethnic groups.
- **Epidemiology of HIV Infection Through 2015.** This CDC slide set includes numerous tables, charts, and graphs with recent and historical information on HIV and AIDS diagnoses, including breakdowns by race/ethnicity, mode of exposure, gender, age, and state or territory.
**HIV Surveillance by Race/Ethnicity.** This CDC slide set focuses specifically on racial and ethnic patterns and disparities in different racial/ethnic groups, including Asian Americans and Native Hawaiians and Other Pacific Islanders.

**Clinician’s Guide to Working with Asians & Pacific Islanders Living with HIV.** Booklet from the Asian and Pacific Islander Wellness Center.

**BESAFE: A Cultural Competency Model for Asians and Pacific Islanders.** This 96-page workbook was produced by the National Minority AIDS Education and Training Center and Howard University.

**Selected Recent Articles and Research Papers About HIV/AIDS and Hepatitis in Asian and Pacific Islander Americans**

*Community-Based Participatory Research Studies on HIV/AIDS Prevention, 2005-2014.* *(Jacobs Journal of Community Medicine)*


*Assessing Collectivism in Latino, Asian/Pacific Islander, and African American Men Who Have Sex with Men: A Psychometric Evaluation.* *(AIDS Education and Prevention)*

*New Documentary Examines Hepatitis B Among Asian Americans* *(Hepmag)*

*Hepatocellular Carcinoma and Viral Hepatitis in New York City.* *(Clinical Infectious Diseases)*

*Revising the American Dream: How Asian Immigrants Adjust After an HIV Diagnosis.* *(Journal of Advanced Nursing)*

*Substance Use Among a National Sample of Asian/Pacific Islander Men Who Have Sex with Men in the U.S.* *(Journal of Psychoactive Drugs)*

*Disparities in Hospitalizations Among HIV-Positive Individuals for Native Hawaiians and Asians Compared to Whites in Hawai‘i.* *(Hawaii Journal of Medicine and Public Health)*

*“Know Hepatitis B”: A Multilingual Communications Campaign Promoting Testing for Hepatitis B Among Asian Americans and Pacific Islanders.* *(Public Health Reports)*

*HBV Outreach Programs Significantly Increase Knowledge and Vaccination Rates Among Asian Pacific Islanders.* *(Journal of Community Health)*

*Assessment of HBV Preventive Services in a Medically Underserved Asian and Pacific Islander Population Using Provider and Patient Data.* *(Journal of General Internal Medicine)*

**Materials for HIV Long-Term Survivors Day (June 5)**

HIV Long-Term Survivors Day (HLTSD) is commemorated on June 5—the anniversary of the day in 1981 when the CDC reported the first cases among gay men of a mysterious illness that would later become known as AIDS. According to its website, HLTSD celebrates “those who have defied the odds by living with HIV for decades. June 5 is about coming together and realizing that we are not alone.” In 2017, nearly 60% or all people living with HIV in the U.S. are over 50 years old, and by 2020, this proportion is projected to increase to 70%. The theme of HLTSD 2017 is ‘HIV-resilient’: “Our focus is on ensuring that HIV long-term survivors are front and center in the current HIV dialogue.” To help commemorate the day, we’ve compiled an annotated list of online resources focusing on HIV long-term survivors.

**HIV Long-Term Survivors Day website**: This site includes background information about HLTSD, long-term survivors, and events to mark the day.

**LetsKickASS – AIDS Survivor Syndrome**: This is a grassroots organization that is responsible for HLTSD and that is “devoted to improving the lives of survivors by empowering, engaging, unifying, and elevating survivors to reclaim our lives, end isolation, and envisioning a future we never dreamed we’d live.”

**Pre-HAART Long-Term Survivors Forum**: This question-and-answer forum is for persons who have been living with HIV since before 1996. That’s the year when highly active antiretroviral therapy (HAART)—the first very effective treatments to suppress and control HIV—first became available.

**Strategies to Improve the Health of Older Adults Living with HIV** (National Center for Innovation in HIV Care)

**Long-Term HIV/AIDS Survivors Meet for a Summit on Thriving** (Poz)

**The POZ 100: Celebrating Long-Term Survivors** (Poz)

**A Long-Term Survivor Speaks Out** (Poz)

**We Are All Long-Term Survivors** (Poz)

**‘HIV Long-Term Survivors Declaration’ Offers Road Map** (Poz)

**5 Steps to Improve the Health of Older Adults Living with HIV** (Poz)

**Higher Rates of Five Major Non-AIDS Comorbidities After Age 50** (TheBodyPro)
Studies Look at Brain and Cognitive Changes in People with HIV as They Age (AIDSmap)

High Prevalence of Geriatric Conditions in HIV-Positive Patients Aged Over 50 in San Francisco (AIDSmap)

Seniors with HIV Have a Higher Risk of Many Chronic Health Conditions (Poz); related coverage from AIDSmap

Seniors Are at Higher Risk of Drug Conflicts with Hepatitis C Treatment (Hepmag)

French study reveals the growing complexity of medical needs as people with HIV age (AIDSmap)

New Clinical Resources: Mental Health Needs of People Aging With HIV/AIDS (TheBodyPro)

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RECENT RESEARCH ON THE CONTINUUM OF CARE/TREATMENT CASCADE FOR HIV AND VIRAL HEPATITIS

This newsletter section includes the titles, authors, and links to abstracts of recent research related to the continuum of care for HIV and viral hepatitis. This includes research on interventions to increase awareness of HIV and/or viral hepatitis status through expanded testing; to increase linkage to and retention in care and treatment; and to attain and maintain desired health outcomes. Papers are listed alphabetically according to the lead author’s last name.


Engagement in Care of High-Risk Hepatitis C Patients with Interferon-Free Direct-Acting Antiviral Therapies. By J.B. Dever, J.H. Ducom, A. Ma, and others, in Digestive Diseases and Sciences.


The HIV Continuum of Care in European Union Countries in 2013: Data and Challenges. By A. Gourlay, T. Noori, A. Pharris, and others, in Clinical Infectious Diseases.


Monitoring HIV Treatment and the Health Sector Cascade: From Treatment Numbers to Impact. By D. Low-Beer, M. Beusenberg, C. Hayashi, and others, in AIDS and Behavior.


HIV Stigma, Retention in Care, and Adherence Among Older Black Women Living with HIV. By T.

The North Carolina HIV Bridge Counselor Program: Outcomes from a Statewide Level Intervention to Link and Re-Engage HIV-Infected Persons in Care in the South. By A.C. Seña, J. Donovan, H. Swygard, and others, in Journal of Acquired Immune Deficiency Syndromes.


RECENT RESEARCH ON HIV AND HEPATITIS HEALTH DISPARITIES AND AFFECTED POPULATIONS

This section includes the titles, authors, and links to abstracts of recent research. Papers are listed alphabetically according to the lead author’s last name.


Mobile Phone and Internet Use Mostly for Sex-Seeking and Associations with Sexually Transmitted Infections and Sample Characteristics Among Black/African American and Hispanic/Latino Men Who Have Sex with Men in 3 U.S. Cities. By J.E. Allen, G. Mansergh, M.J. Mimiaga, and others, in Sexually Transmitted Diseases.


Delay in Sexual Maturation in Perinatally HIV-Infected Youth Is Mediated by Poor Growth. By A. Bellavia, P.L. Williams, L.A. Dimeglio, and others, in AIDS.

A Randomized Controlled Trial of Rise, a Community-Based Culturally Congruent Adherence Intervention for Black Americans Living with HIV. By L.M. Bogart, M.G. Mutchler, B. McDavitt, and others, in Annals of Behavioral Medicine.

Syringe Sharing Among a Prospective Cohort of Street-Involved Youth: Implications for Needle Distribution Programs. By N. Bozinoff, E. Wood, H. Dong, and others, in AIDS and Behavior.


Racial Disparities in HIV. By R.D. Burt and S.N. Glick, in Lancet HIV.


Geographic Disparities in Access to Syringe Services Programs Among Young People with Hepatitis C Virus Infection in the U.S. By L. Canary, S. Hariri, C. Campbell, and others, in Clinical Infectious Diseases.


What Influences Quality of Life in Older People Living with HIV? By J. Catalan, V. Tuffrey, D. Ridge, and others, in AIDS Research and Therapy. Free full text also available.


Improving Health and Reducing Comorbidity Associated with HIV: The Development of TAVIE en Santé, a Web-Based Tailored Intervention to Support the Adoption of Health Promoting Behaviors Among People Living with HIV. By J. Côté, S. Cossette, P. Ramirez-Garcia, and others, in Biomedical Research International. Free full text also available.


Randomised Controlled Trial of a Sexual Risk Reduction Intervention for STI Prevention Among Men Who Have Sex with Men in the U.S.A. By L.A. Eaton, S.C. Kalichman, M.O. Kalichman, and others, in Sexually Transmitted Infections.


Social, Economic, and Health Disparities Among LGBT Older Adults. By C.A. Emlet, in Generations. Free full text also available.


Lack of Support for Socially Connected HIV-1 Transmission Among Young Adult Black MSM. By K. Fujimoto, L.M. Coghill, C.A. Weier, and others, in AIDS Research and Human Retroviruses.


Body Image and Condomless Anal Sex Among Sexual Minority Men Living with HIV. By S. Gholizadeh, B.M. Rooney, E.L. Merz, and others, in AIDS and Behavior.

An Increased Rate of Fracture Occurs a Decade Earlier in HIV+ Compared to HIV- Men in the Multicenter AIDS Cohort Study (MACS). By A. Gonciulea, R. Wang, K.N. Althoff, and others, in AIDS.

Sources of Racial Disparities in HIV Prevalence in Men Who Have Sex with Men in Atlanta, GA, USA: A Modelling Study. By S.M. Goodreau, E.S. Rosenberg, S.M. Jenness, and others, in Lancet HIV.


Change in Subjective Social Status Following HIV Diagnosis and Associated Effects on Mental and Physical Health Among HIV-Positive Gay Men in Australia. By W. Heywood and A. Lyons, in Psychology and Health.


Disability Among Middle-Aged and Older Persons with HIV Infection. By N.A. Johs, K. Wu, K. Tassiopoulos, and others, in Clinical Infectious Diseases.

Sociodemographic and Substance Use Disorder Determinants of HIV Sexual Risk Behavior in Men and Women in Outpatient Drug Treatment in the NIDA National Drug Abuse Treatment Clinical Trials Network. By J.D. Kidd, S. Tross, M. Pavlicova, and others, in *Substance Use and Misuse*.


Sexual Orientation Differences in Health and Wellbeing Among Women Living with HIV in Canada: Findings from a National Cohort Study. By C.H. Logie, A. Lacombe-Duncan, Y. Wang, and others, in *AIDS and Behavior*.


A Randomized Clinical Trial of Adolescents with HIV/AIDS: Pediatric Advance Care Planning. By M.E. Lyon, L.J. D'Angelo, R.H. Dallas, and others, in *AIDS Care*.


Effects of Parental Monitoring and Knowledge on Substance Use and HIV Risk Behaviors Among Young Men Who have Sex with Men: Results from Three Studies. By B. Mustanski, G. Swann, M.E. Newcomb, and N. Prachand, in AIDS and Behavior.


Scenes as Micro-Cultures: Examining Heterogeneity of HIV Risk Behavior Among Gay, Bisexual, and Other Men Who Have Sex with Men in Toronto, Canada. By S.W. Noor, B.D. Adam, D.J. Brennan, and others, in Archives of Sexual Behavior.


A Tale of Two Countries: All-Cause Mortality Among People Living with HIV and Receiving Combination Antiretroviral Therapy in the U.K. and Canada. By S. Patterson, S. Jose, H. Samji, and others, in HIV Medicine.

Awareness and Understanding of HIV Non-Disclosure Case Law Among People Living with HIV Who Use Illicit Drugs in a Canadian Setting. By S. Patterson, A. Kaida, G. Ogilvie, and others, in International Journal of Drug Policy.


The Relationship Between Caffeine Intake and Immunological and Virological Markers of HIV Disease Progression in Miami Adult Studies on HIV Cohort. By V. Ramamoorthy, A. Campa, M. Rubens, and others, in *Viral Immunology*.

The Relationship Between Higher Social Trust and Lower Late HIV Diagnosis and Mortality Differences by Race/Ethnicity: Results from a State-Level Analysis. By Y. Ransome, A. Batson, S. Galea, and others, in *Journal of the International AIDS Society*.

Small-Group Randomized Controlled Trial to Increase Condom Use and HIV Testing Among Hispanic/Latino Gay, Bisexual, and Other Men Who Have Sex with Men. By S.D. Rhodes, J. Alonzo, L. Mann, and others, in *American Journal of Public Health*.


An Update on the Barriers to Adherence and a Definition of Self-Report Non-Adherence Given Advancements in Antiretroviral Therapy (ART). By J.A. Sauceda, T.B. Neilands, M.O. Johnson, and P. Saberi, in *AIDS and Behavior*.

Patterns of Mood and Personality Factors and Associations with STI/HIV-Related Drug and Sex Risk Among African American Male Inmates. By J.D. Scheidell, C.W. Lejuez, C.E. Golin, and others, in *Substance Use and Misuse*.


Willingness to Distribute Free Rapid Home HIV Test Kits and to Test with Social or Sexual Network Associates Among Men Who Have Sex with Men in the United States. By A. Sharma, P.R. Chavez, R.J. MacGowan, and others, in *AIDS Care*.


Association of HIV Diagnosis Rates and Laws Criminalizing HIV Exposure in the United States. By P. Sweeney, S.C. Gray, D.W. Purcell, and others, in AIDS.


Lifetime and Recent Alcohol Use and Bone Mineral Density in Adults with HIV Infection and Substance Dependence. By A.S. Ventura, M.R. Winter, T.C. Heeren, and others, in Medicine.


Acceptability of a Mobile Health Intervention to Enhance HIV Care Coordination for Patients with Substance Use Disorders. By R.P. Westergaard, A. Genz, K. Panico, and others, in Addictive Science and Clinical Practice.

