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NEWS ROUNDUP

Trump Administration’s FY18 Budget Proposal Includes Major Cuts to Health Programs

The Trump Administration’s Fiscal Year 2018 (FY18) budget proposal includes deep cuts to many health programs, including those providing direct services to persons living with HIV. Shortly after the budget was released in late May, various groups, including the American Association for the Advancement of Science, the Treatment Action Group, and The Fenway Institute, published separate summaries of proposed health and science budget changes, including those expected to impact HIV, viral hepatitis, and tuberculosis (TB). These proposed changes include:

Domestic Programs:

- a $7.7 billion (22%) reduction to research at the National Institutes of Health;
- an $838 million (18%) cut to the National Institute of Allergy and Infectious Diseases, which conducts extensive HIV/AIDS research;
- a 17% funding cut to CDC-funded programs for the prevention of HIV, viral hepatitis, sexually transmitted infections, and TB;
- $59 million in cuts to the Ryan White HIV/AIDS Program; and
- eliminating the Minority HIV/AIDS Initiative (MAI), AIDS Education Training Centers, and Special Projects of National Significance (SPNS)

In addition, the budget would provide flat funding of CDC’s hepatitis prevention programs and continue to limit the use of federal funding to purchase syringes.

International Programs:

- cutting $700 million from the President’s Emergency Plan for AIDS Relief (PEPFAR) and $225 million from the Global Fund to Fight AIDS, Tuberculosis, and Malaria;
- eliminating the Fogarty International Center, which trains scientists around the world in HIV and TB research;
- eliminating U.S. funding commitments for the International AIDS Vaccine Initiative (IAVI) and microbicides research; and
- cutting $62 million from global TB programs at the U.S. Agency for International Development.

Longer-Term Budget Impacts

Looking beyond FY18, The New York Times published an interactive chart, How Trump’s Budget Would Affect Every Part of Government, that has The Times’ projections of federal spending over the next 10 years, based on the Trump budget proposal, compared to projected spending under current policies. These include 10-year cuts totaling $2.02 trillion (28%) to all health programs; $627 billion to Medicaid (a total that does not fully account for the even larger Medicaid cuts under the proposed American Health Care Act); $87 billion to the National Institutes of Health; and $18 billion to the CDC.

Many policy, research, and health care organizations, news agencies, and patient advocacy groups issued statements responding to the Trump Administration’s budget proposal and analyzing its projected impacts. These include a joint statement by AIDS United, the National Alliance of State and Territorial AIDS Directors, the National Coalition of STD Directors, NMAC, and The AIDS Institute. For your convenience, we have provided links to selected other statements and analyses that focus on research and health funding here: American Academy of Pediatrics; American Association for the Advancement of Science; Association of American Medical Colleges; American Public Health Association; AVAC; Health GAP (Global Access Project); Project Inform; Science Speaks; The Fenway Institute.


Institute; and Treatment Action Group. In addition, the Kaiser Health News daily briefings for May 24 link to numerous news summaries of the proposed FY18 budget proposal in the Administration News section.

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CBO Projects AHCA Would Increase Uninsured by 23 Million and Reduce Deficit by $119 Billion
By a vote of 217 to 213 on May 4, the U.S. House of Representatives passed an amended version of its American Health Care Act (AHCA) – health care legislation designed to repeal and replace the Patient Protection and Affordable Care Act, which is widely known as Obamacare. In last month’s newsletter, we provided detailed information on the provisions of AHCA passed by the House and the responses of various HIV, health, and other groups to the bill. In this article, we will focus on the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) assessment of the AHCA published in their report, H.R. 1628: American Health Care Act of 2017 – As passed by the House of Representatives on May 4, 2017. For simplicity and clarity, when this article refers to AHCA, we generally mean the May 4 version passed by the House, unless otherwise noted. Likewise, when we discuss the CBO/JCT’s projections for the number of persons uninsured under AHCA and its impacts on taxes and the federal budget, these figures are compared to a baseline scenario in which Obamacare remained in effect.

Health Insurance Coverage: By 2026, a total of 23 million more persons would lack health insurance under the AHCA compared to Obamacare. This estimate represents a modest improvement over an earlier version of the AHCA negotiated in March, which had been projected to result in 24 million more uninsured persons by 2026. “CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under H.R. 1628 than under current law,” the report notes. “The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 23 million in 2026. In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law. Under the legislation, a few million of those people would use tax credits to purchase policies that would not cover major medical risks.”

Stability of Insurance Markets: “The agencies [CBO and JCT] expect that the nongroup market in many areas of the country would continue to be stable in 2020 [under AHCA] and later years as well, including in some states that obtain waivers from market regulations . . . However, the agencies estimate that about one-sixth of the population resides in areas in which the nongroup market would start to become unstable beginning in 2020. That instability would result from market responses to decisions by some states to waive two provisions of federal law, as would be permitted under H.R. 1628. One type of waiver would allow states to modify the requirements governing essential health benefits (EHBs), which set minimum standards for the benefits that insurance in the nongroup and small-group markets must cover. A second type of waiver would allow insurers to set premiums on the basis of an individual’s health status if the person had not demonstrated continuous coverage; that is, the waiver would eliminate the requirement for what is termed community rating for premiums charged to such people.” In plain language, this means that states might be granted waivers that allow insurers to offer health policies that don’t cover some or all of the EHBs required under Obamacare or that charge much higher rates for people with pre-existing conditions than for healthier persons.

Effects on Premiums and Out-of-Pocket Payments: The AHCA “would tend to increase such premiums
before 2020, relative to those under current law — by an average of about 20% in 2018 and 5% in 2019, as the funding provided by the act [AHCA] to reduce premiums had a larger effect on pricing.” Starting in 2020, “average premiums would depend in part on any waivers granted to states and on how those waivers were implemented and in part on what share of the funding available from [AHCA’s] the Patient and State Stability Fund was applied to premium reduction.” People who are young and in good health could see substantial decreases in their insurance premiums under AHCA, especially in states that obtain waivers allowing insurers to offer plans lacking coverage for some or all of the EHBs required under Obamacare, or charging much higher rates for older persons or persons with pre-existing health conditions. It is worth noting, however, that even young, healthy persons could face higher net health expenses if they chose an inexpensive plan with limited coverage but later became sick or chose to access services, such as pregnancy and maternity care, that would have been covered as EHBs under Obamacare plans but were not included in their plan.

“Although the agencies [CBO and JCT] expect that the legislation would increase the number of uninsured broadly, the increase would be disproportionately larger among older people with lower income—particularly people between 50 and 64 years old with income of less than 200% of the federal poverty level” [FPL]. Older, low-income people would be particularly hard hit. Table 5 of the report summarizes different scenarios regarding the projected premiums under Obamacare and AHCA in 2026 for the nongroup, individual health insurance market. These projections include estimates of the total premium charged, premium tax credits, and net premium paid by people of different ages, income levels, and states of residence – in particular, whether those persons live in states that adopt waivers to Obamacare’s insurance market regulations.

For example, the table indicates that, under Obamacare, a 64-year-old with an income of $26,500 (175% of FPL) would be charged $15,300 in annual premiums but would be eligible for a $13,600 premium tax credit, which would reduce their net annual payment for health insurance to just $1,700. Under AHCA, however, a 64-year-old with an annual income of $26,500 who lived in a state that does not request waivers from Obamacare’s market regulations would be charged $21,000 in annual premiums, but would be eligible for only a $4,900 premium tax credit, making their net annual payment for health insurance $16,100 – about 9.5 times higher. Such high premiums would be unaffordable for many older low- and middle-income persons.

**Federal Budget Effects:** CBO and JCT estimate that enactment of the AHCA would decrease federal deficits by a net $119 billion over the period from 2017 through 2026. That change would result from a $1,111 billion decrease in direct spending, largely offset by a $992 billion reduction in revenues. The total projected deficit reduction under the House version of AHCA includes the following amounts:

- a reduction of $834 billion in federal outlays for Medicaid;
- savings of $665 billion stemming mainly from eliminating, in 2020, the ACA’s subsidies for nongroup health insurance – which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments;
- savings of $23 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation resulting from net decreases in most years in the number of people estimated to enroll in employment-based health insurance coverage; and
- savings of $6 billion from repealing a tax credit for certain small employers who provide health insurance to their employees.
Those decreases in the deficit would be largely offset by:

- a cost of $375 billion for the new tax credit for nongroup insurance established by the legislation in 2020;
- a reduction in revenues of $210 billion from eliminating the penalties paid by uninsured people ($38 billion) and employers ($171 billion);
- an increase in spending of $117 billion for the Patient and State Stability Fund grant program; and
- a net increase in spending of $43 billion for the Medicare program stemming from changes in payments to hospitals that serve a disproportionate share of low-income patients.

**Future of AHCA:** As this newsletter went to press on June 6, members of the U.S. Senate were still considering the provisions of the House bill and working on their own version incorporating the unique concerns of Senators and their constituents. To pass under the budget reconciliation process, the Senate bill will need at least 50 votes, with Vice President Mike Pence as a tie-breaker in the event of a 50-50 tie. Since there are just 52 Republican Senators and no Democratic Senators are expected to vote for AHCA, any bill developed by the Senate can only afford to lose the votes of two Republican Senators. To date, negotiations on the Senate version of the health bill have been going slowly, and it is not clear when – or whether – the Senate will pass legislation. If they do, then the House and Senate will need to negotiate the differences between their two bills and develop a compromise bill that can garner the votes needed to pass both the House and Senate and become law.

**KFF Brief: What Is at Stake in ACA Repeal and Replace for People with HIV?**

The Kaiser Family Foundation (KFF) published a 7-page issue brief, *What Is at Stake in ACA Repeal and Replace for People with HIV?*, soon after the U.S. House passed its version of the American Health Care Act (AHCA) on May 4. The brief examines the potential effects of different Affordable Care Act (ACA or Obamacare) repeal scenarios and related administrative actions on people living with HIV (PLWH). It focuses primarily on three main policy areas of particular importance to PLWH: (1) the future of Obamacare’s Medicaid expansion; (2) changes to the traditional Medicaid program; and (3) the proposed reforms affecting the private health insurance market, including changes to Obamacare’s insurance marketplaces.

Of these policy areas, changes to Medicaid would likely have the greatest impact on people living with HIV, according to KFF. Medicaid is currently the single largest source of health coverage in the U.S. for PLWH, and its role for PLWH has expanded significantly under Obamacare. Before Obamacare took effect, individuals could not qualify for Medicaid based on income alone. Instead, they had to have both a low income and another condition or characteristic – such as disability, pregnancy, or being parents – to be eligible. These eligibility requirements excluded most low-income childless adults from Medicaid coverage, including many low-income PLWH who could not qualify for Medicaid unless they were already sick and disabled, often as a result of developing AIDS. Obamacare changed this by requiring states that expanded their Medicaid programs to cover persons whose incomes were below 138% of the federal poverty level (FPL) based on their income and residency status alone – other conditions or characteristics were no longer required.
By May 2017, 32 states (including the District of Columbia) where an estimated 62% of PLWH live had adopted Medicaid expansion. Under Obamacare, the federal government provided those states with 100% federal funding (often referred to as matching funds) for the costs of covering newly eligible adults under Medicaid expansion from 2014 to 2016. This level of federal assistance was scheduled under Obamacare to phase down to 95% in 2017 and to 90% by 2020 and beyond. Although the version of the AHCA passed by the U.S. House would retain Medicaid expansion, it would provide less generous federal matching funding, beginning in 2020, for new Medicaid enrollees and for existing enrollees who did not have continuous coverage. According to KFF, “A less generous match could mean states would be less willing to cover the new adult population in the years to come and, in fact, several states already have triggers in place to rescind coverage for the current group if the federal match declines to certain levels. It would also provide a disincentive for other states to expand in the future.”

KFF also notes that the AHCA proposes a per capita cap on Medicaid funding to limit federal spending and increase states’ flexibility in the use of Medicaid funds – an approach that could limit health care access for PLWH. “Under restructured and constrained financing, states would probably respond by reducing services or eligibility to accommodate a loss in federal dollars,” according to KFF. “Beneficiaries may see increased cost-sharing and providers, reductions in reimbursement rates. As these programs could be structured in a multitude of ways, it will be important to watch how proposals might impact access to coverage for people with HIV in terms of eligibility, benefits, cost-sharing, beneficiary protections, and enrollment requirements. These proposals to change per beneficiary spending would apply to the HIV disability population in traditional Medicaid as well as the newly eligible expansion population.”

In addition to the changes that the AHCA would make to Medicaid, Section 1115 of the Social Security Act gives the secretary of Health and Human Services (HHS) authority to approve Medicaid experimental, pilot, or demonstration projects. In March, HHS secretary Thomas Price and Centers for Medicaid and Medicare Services (CMS) administrator Seema Verma sent a letter to governors outlining the Trump Administration’s approach to Medicaid policy. The letter indicated that it would consider waivers that include higher beneficiary cost-sharing for state Medicaid programs and that adopt alternative benefit designs, which could include features such as health savings accounts and work requirements – “all provisions that could impact access to care and treatment for people with HIV,” according to KFF.

Proposed changes to the individual insurance market under the AHCA could also have major impacts on PLWH, according to KFF. These include changes in the Obamacare provisions that:

- require insurers to cover pre-existing conditions, prevent them from charging higher rates based on health status, and prohibit them from imposing lifetime and annual limits on coverage;
- provide income-based tax credits and cost-sharing subsidies that help make insurance premiums affordable and limit out-of-pocket expenses for people with low incomes; and
- require that health insurance policies cover 10 categories of essential health benefits.

As described in earlier articles in this newsletter, if the current House version of the AHCA became law, it would eliminate Obamacare’s current income-based tax credits and cost-sharing subsidies, and replace these with tax credits based on age. These age-based credits are much less generous for people who have low incomes, which is the case for many PLWH. The House version of the AHCA would also allow states to obtain waivers that permit insurers in the state to issue policies that lack coverage of essential
health benefits or charge higher rates for people with pre-existing conditions, such as HIV.

The federal government also has the capacity to reverse past regulations and create new regulations or modify health policy by issuing subregulatory guidance. “Changes to rule making can impact how the ACA is implemented including through benefit design, cost-sharing, oversight, beneficiary protections, and market stability,” KFF notes. “For instance, HHS released a final Market Stabilization rule in April of 2017 that will change continuity of coverage requirements, shorten the open enrollment period, tighten special enrollment periods, loosen Actuarial Value (plan generosity) requirements, and pullback on network adequacy and essential community provider requirements and regulatory oversight. Loosening of the network and essential community provider networks in particular could be limiting for people with HIV as it may mean fewer Ryan White and infectious disease providers in plan networks.”

Implementation of the changes described above would likely increase the importance of the Ryan White HIV/AIDS Program (RWHAP) for PLWH, according to KFF. “Under an ACA repeal, coverage gains that have occurred as a result of the law through the Marketplaces and Medicaid expansion could be lost. It is likely that individuals who lose coverage would return to Ryan White to meet their full HIV care and treatment needs, but it is unclear whether the program would be able to absorb clients into traditional HIV care and treatment with existing resources and without resorting to waitlists. Additionally, Ryan White is not an insurance program and covers only HIV related care so those who have gained insurance coverage and transition back to Ryan White exclusively would face losing access to coverage for other health conditions and emergency services. While the program would still be permitted to assist clients with the cost of insurance, the ability of Ryan White to do so as commonly as it does today without the ACA’s subsidies and rate setting protections is in question since by statute such arrangements must be cost-effective for the program.” The cuts to the HHS budget in the Trump Administration’s proposed HHS budget for FY18 could also impact the RWHAP. “If cuts are realized, the Ryan White Program may not be able to sustain existing levels of service provision, especially if more individuals seek assistance from a program with less funding.”

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Many HIV+ Persons Who Respond Well to Treatment Have Near-Normal Life Expectancy
The overall health of millions of persons living with HIV have improved dramatically in the two decades since effective combination antiretroviral therapy (ART) first became available in the mid-1990s. In recent years, a number of studies have also documented large increases in the life expectancy of some HIV+ persons – especially those who are diagnosed relatively early in the course of infection and who receive treatment promptly. Now a very large study has confirmed that people who respond well to ART during their first year on treatment achieve a near-normal life expectancy.

In the study, a multinational research group known as the Antiretroviral Therapy Cohort Collaborative analyzed data from 18 European and North American cohort studies that tracked the health of nearly 90,000 persons who started ART during different time periods, ranging from 1996 to 2010. In particular, the researchers examined death rates during the first 3 years after people started ART and used that information to estimate future life expectancy. They found that, between 1996 and 2010, the average life expectancy of people receiving ART increased about 10 years for both men and women. For people who started ART between 2008 and 2010 and who were still alive with a CD4 T-cell count over 350 a year after beginning treatment, their life expectancy is similar to that of the general (non-HIV-infected)
population. For example, the researchers estimate that a 20-year-old who started and responded well to ART during that period could expect to live, on average, to the age of 78. However, the study shows that, compared to the general population, people starting ART treatment still have an increased risk of death during the first year of treatment – a period when some have low CD4 counts that place them at risk for life-threatening opportunistic illnesses.

It is also worth noting that the overall life expectancy figures are averages and do not mean that all groups benefit equally well. In particular, people who inject drugs and those who start ART with low CD4 cell counts have lower life expectancies than people who do not inject drugs and start ART with higher CD4 counts. Interestingly, the life expectancy benefits of ART were somewhat better in Europe than in North America. The researchers also found that the direct effects of ART – reduced viral load and higher CD4 counts – weren’t the only factors that increased the life expectancies of HIV+ persons receiving treatment. Improved care for other health conditions, such as heart disease, diabetes, and malignancies, also had an impact. The study indicated that, over the years, there were particularly large decreases in the death rates due to heart and liver disease, including hepatitis C (HCV). Since the study included only persons who started ART between 1996 and 2010, it does not provide any information about the additional health benefits people coinfected with HIV drug regimens that have become available during the past few years.

Reported U.S. Cases of Acute Hepatitis C Nearly Tripled Between 2010 and 2015

Reported new cases of acute hepatitis C virus (HCV) infection nearly tripled in the U.S. from 2010 through 2015, rising from 850 to 2,436 cases annually during the period, according to the most recent data from CDC’s National Notifiable Diseases Surveillance System. CDC attributes the jump in acute HCV cases to new infections associated with rising rates of injection drug use, and, to a much lesser extent, improved case detection. Although several analyses have shown that most newly acquired HCV infections occur among young White persons living in non-urban areas – especially in the Appalachian, Midwestern, and New England states – there is also evidence that HCV incidence is increasing throughout the country. It is worth noting that the states with the highest rate of new HCV infections (West Virginia, Kentucky, and Tennessee) did not receive CDC support for case finding between 2011 and 2015. As a result, CDC estimates that, adjusting for under-ascertainment and under-reporting, approximately 33,900 new HCV infections occurred in 2015.

Deaths among persons with chronic HCV – primarily older adults 55 to 64 years old – increased from 2006 through 2010, and by 2013, HCV-associated deaths exceeded the total deaths from 60 other infectious diseases as underlying causes. Mortality data indicate the number of HCV-associated deaths rose about 11% from 2011 through 2014, but then decreased slightly (0.2%) to 19,629 in 2015. CDC notes, however, that HCV-associated deaths are largely underestimated: “the only large U.S. study of deaths among persons with confirmed HCV infection indicated that only 19% had HCV listed anywhere on the death certificate despite 75% having evidence of substantial liver disease.” To increase the proportion of persons with HCV who are tested and linked to care and treatment, CDC and the U.S. Preventive Services Task Force recommend one-time testing for HCV infection among all persons born during the period from 1945 through 1965 and among those in groups at increased risk for HCV.
CDC’s 2015 viral hepatitis surveillance summary also includes the latest data for acute hepatitis A (HAV) and hepatitis B (HBV) infections. Although the reported cases of acute HAV were nearly identical in 2011 and 2015 (1,393 and 1,390, respectively), there was a spike in acute HAV cases to 1,781 during 2013. CDC attributes this temporary increase, in part, to a 2013 HAV outbreak among persons who consumed imported pomegranate seeds in Hawaii and several states in the southwestern U.S. The number of reported cases of acute HBV increased from 2,903 in 2011 to 3,370 in 2015. After adjusting for under-ascertainment and under-reporting, CDC estimates that the actual number of new HAV and HBV infections during 2015 were about 2,800 and 21,900, respectively.

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CDC Finds Many States Lack Laws and Policies That Would Effectively Reduce HCV Transmission

Most new HCV infections in the U.S. are the result of injection drug use. As noted in the news feature above, an estimated 33,900 infections occurred during 2015. Creating and strengthening public health laws and policies tailored to the needs and experiences of persons who inject drugs (PWID) is one potential strategy for fighting HCV and ultimately the epidemic. In particular, providing PWID with access to safe injection equipment can prevent new HCV infections. In addition, the current highly effective HCV therapies can cure more than 90% of those infected, thereby reducing the risk for HCV-associated death and transmission of the virus to others.

To evaluate factors that may facilitate or limit PWID’s access to HCV prevention and treatment services, CDC researchers assessed different states’ laws governing access to safe injection equipment and their eligibility requirements for HCV treatment among PWID. They reviewed state data on acute HCV rates, and categorized states based on an analysis of state laws related to access to clean needles and syringes and Medicaid HCV treatment policies associated with sobriety requirements. In their analysis of state legislation, the researchers focused on: 1) the authorization of syringe exchange programs; 2) the scope of drug paraphernalia laws; and 3) retail sales of needles and syringes. They evaluated the features of state laws in depth and then grouped those laws into five categories (most comprehensive, more comprehensive, moderately comprehensive, less comprehensive, and least comprehensive) based on the presence or absence of key features. The researchers also looked at states’ Medicaid policies affecting access to HCV treatment among PWID. States that had sobriety requirements for receiving HCV treatment were categorized as restrictive, while those without sobriety requirements were considered permissive.

The CDC analysis found that three states – Maine, Nevada, and Utah – had the most comprehensive laws related to HCV prevention. These states’ laws authorized syringe exchange without any jurisdictional limitations, removed barriers to possessing and distributing syringes and needles through drug paraphernalia laws, and explicitly allowed the retail sale of syringes to PWID. In contrast, 18 states had laws categorized as the least comprehensive for HCV prevention. In particular, these states had no laws authorizing syringe exchange programs, decriminalizing possession and distribution of syringes and needles, or allowing the retail sale of syringes without a prescription.

Regarding access to HCV treatment, the CDC researchers found that 16 states had permissive policies that did not require a period of sobriety or only required screening and counseling to receive HCV treatment through Medicaid. They determined that 24 states had restrictive policies for HCV treatment,
requiring that PWID have a period of sobriety before receiving HCV treatment through Medicaid. It is worth noting that the 24 treatment-restrictive states included 11 with the least comprehensive HCV prevention laws. Of the 17 states in which HCV incidence was above the national average, only five (Massachusetts, New Mexico, North Carolina, Pennsylvania, and Washington) have permissive Medicaid treatment policies.

In addition, only three states (Massachusetts, New Mexico, and Washington) had both a most comprehensive or more comprehensive set of HCV prevention laws and a permissive Medicaid treatment policy that might affect access to both HCV preventive and treatment services among PWID. “The findings from this assessment of state laws and one component of Medicaid treatment policies can inform jurisdictions when building their capacity to prevent the spread of HCV in their communities,” the CDC researchers concluded. “Whereas any one policy can have a positive impact on public health, many factors contribute to the prevalence of disease, and it is important for policy makers and public health officials to work together to understand the various needs of particular populations to prevent HCV transmission and disease.”

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UNAIDS and the Global Fund Publish Guidance on HIV Human Rights Programs
UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) recently published two guidance documents designed to help countries integrate human rights principles into their HIV prevention, testing, and treatment programs. The 64-page Fast Track and Human Rights presents the following key human rights principles for HIV services:

- availability, accessibility, acceptability, and good quality of services;
- equality and non-discrimination;
- privacy and confidentiality;
- respect for personal dignity and autonomy; and
- meaningful participation and accountability.

Fast Track also provides three checklists to support and guide the design, monitoring, and evaluation of HIV services that integrate the above human rights principles in HIV prevention, testing, and treatment services.

The second document, HIV, Human Rights, and Gender Equality, is designed to help applicants seeking support from the Global Fund take steps to remove human rights and gender-related barriers to their HIV services. It also provides guidance on implementing human rights-based and gender-responsive approaches to HIV. Together, the documents will inform the development of Global Fund concept notes, national Fast-Track plans, and other work to accelerate the response to HIV, according to UNAIDS. “We must go beyond talking about HIV-related discrimination and human rights violations,” noted Michel Sidibé, UNAIDS executive director. “Now is the time to act and support governments, civil society, and affected communities to respond to these challenges through programs to advance human rights, dignity, and equity.”

In related news, more than 100 representatives of governments, international organizations, and other groups called for increased efforts to eliminate discrimination in health care at an event, Catalyzing
Global Action to Stop Discrimination in Health Care, on May 25 in Geneva, Switzerland. The participants expressed their support for UNAIDS’s Agenda for Zero Discrimination in Health Care. The stated aim of the 8-page agenda is “to create a world in which everyone, everywhere, enjoys health services without discrimination, and where the health workforce is empowered to provide discrimination-free health care.”

OTHER NEWS REPORTS AND MATERIALS

VA Has Treated Over 80,000 Persons for Hepatitis C; Cure Rates Over 90%
Between 2014 and January 2017, the U.S. Department of Veterans Affairs (VA) treated more than 80,000 veterans living with chronic hepatitis C (HCV) infection and achieved cure rates over 90%, according to a recent VA blog post marking Hepatitis Awareness Month. The post, written by Elizabeth Maguire of the VA’s Center for Healthcare Organization and Implementation Research, summarized the VA’s recent progress in HCV outreach, testing, and treatment. By the end of 2016, the VA had performed HCV testing on 75% of the VA’s patients born between 1945 and 1965; this age cohort – the so-called Baby Boomer generation – has a high prevalence of HCV. Maguire noted that the VA is continuing to treat about 2,000 veterans a month and that approximately 64,000 veterans with HCV in VA care were potentially eligible for treatment at the end of 2016. “We’re also estimating that as many as 30% of those veterans in VA health care who are still awaiting treatment are not currently willing or able to initiate treatment,” according to Maguire. In March, the VA launched a national advertising campaign about the importance of HCV testing and treatment that features veterans who have been cured of HCV. The blog item urged people who are veterans or know veterans in need of HCV treatment to contact their local VA Health Care System.

Harm Reduction Conference Spotlights Growing North American Opioid Epidemic
The opioid epidemic and rising overdose deaths in Canada and the U.S. were spotlighted at the 25th International Harm Reduction Conference (IHRC) from May 14 through 17 in Montreal. The rising use of synthetic opioids, such as fentanyl, as well as heroin laced with illegally manufactured fentanyl, have led to dramatic increases in opioid overdose deaths. In the U.S., the number of deaths from heroin and non-methadone synthetics, including fentanyl, increased nearly 6-fold between 2002 and 2015, reaching about 20,000 per year by the end of that period. Most of that rise occurred after 2011. Canada has seen a similar spike in opioid deaths, which reached an estimated 2,300 in 2016. The opening session of the IHRC focused on the North American opioid epidemic and overdose deaths, at which Canadian Health Minister Jane Philpott described Canada’s opioid epidemic as worse than any infectious disease epidemic in that nation since the Spanish flu killed 50,000 people in 1918. She noted that, in Canada, opioid deaths have exceeded the peak number of deaths from AIDS reached during the 1990s. As Philpott outlined measures Canada is adopting to expand harm reduction service nationwide, some advocates protested that these steps fall short of what is needed to stem the epidemic. For more information about the IHRC’s opening session and other conference news, you can read a special 12-page bulletin summarizing the conference highlights from the HIV/AIDS news site AIDSmap. Also worth
reading are Harm Reduction International’s detailed report on global harm reduction published late last year, and its reports on harm reduction in North America and the following other regions: Asia, the Caribbean, Eurasia, Latin America, Middle East and North Africa, Oceania, Sub-Saharan Africa, and Western Europe.

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FDA Approves Once-Daily Formulation of Raltegravir (Isentress)
The U.S. Food and Drug Administration (FDA) recently approved a new once-daily formulation of Merck’s HIV integrase inhibitor raltegravir, which will be sold under the trade name Isentress HD. The new formulation will be administered orally as two 600-milligram tablets, and can be taken with or without food in combination with other antiretroviral drugs. FDA approved the original twice-daily formulation of Isentress in October 2007, and it was the only approved drug in the integrase inhibitor class for nearly five years. Integrase inhibitors block the action of integrase, a viral enzyme that inserts HIV’s genetic material into DNA of the host cell – an essential step in viral replication. The more convenient once-daily formulation of raltegravir will add another treatment option for some people living with HIV.

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New National and State Health Profiles Available for HIV/AIDS, viral hepatitis, STDs, and TB
The Centers for Disease Control and Prevention (CDC) recently released new state health profiles that provide an overview of the burden of HIV/AIDS, viral hepatitis, STDs, and TB in the United States as a whole, each of the 50 states, and Washington, D.C. The profiles present the latest nationally representative data, as well as information about CDC-supported prevention and control programs in the U.S. and individual states. Each profile is in the form of a 2-page fact sheet that highlights key statistics and trends, together with charts, graphs, and numerical tables that summarize the following:
- HIV diagnoses by transmission category and race/ethnicity;
- Chlamydia and gonorrhea infections among women stratified by age;
- TB cases by race/ethnicity; and
- CDC funding for HIV, viral hepatitis, STDs, and TB.

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NASTAD Releases 2017 Report on ADAPs and Ryan White Part B Program
In May, the National Alliance of State and Territorial AIDS Directors (NASTAD) published its National ADAP Monitoring Project Annual Report for 2017. NASTAD has compiled extensive information about AIDS Drug Assistance Programs (ADAPs) for more than 20 years. For the first time, their 2017 ADAP annual report also includes important data on the broader Ryan White Part B (RWPB) program and client services, including its budget, expenditures, client utilization, and viral load suppression measures. “This inclusion reflects ADAPs’ synergistic work with the broader RWPB program to ensure that the whole client’s needs are met,” according to NASTAD. “At a time now when ADAPs are documenting program stability, it is imperative that ADAPs look back on how challenges were resolved and look to the
future of client needs and determine ways to prepare for the future. ADAPs are at an unprecedented juncture of being able to look to target resources to populations that need them most, to partner with the RWPB to ensure that the whole client’s needs are met, and to identify ways to bolster treatment for individuals’ health.” NASTAD has also posted two infographics on its website summarizing some of the 2017 report’s findings: 1) Key Characteristics of Ten ADAPs With Highest Rates of Viral Suppression; and 2) Ryan White Part B and ADAP Partnership to Bolster Health Outcomes.

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AIDSinfo Introduces Its Redesigned Website
The U.S. federal AIDSinfo website and its corresponding Spanish language infoSIDA site have recently been upgraded to incorporate new design features and improved navigation. The major enhancements include:

- **Reorganization of patient education materials:** All AIDSinfo patient education materials are now located in a new “Understanding HIV/AIDS” section of the website. These materials include fact sheets, infographics, an HIV/AIDS glossary, and web pages that highlight National HIV/AIDS Awareness Days.

- **Increased connections between AIDSinfo resources:** Website visitors can now readily access resources through different sections of the website. For example, the fact sheets and infographics that relate to each of the federal government’s HIV/AIDS treatment guidelines are now linked to directly from each guideline. This should help health care providers find relevant patient educational materials more easily.

- **Increased prominence of apps:** AIDSinfo’s HIV/AIDS Guidelines, Drug Database, and Glossary apps are now prominently featured in each section of the website. These free apps are available for both iOS and Android devices.

- **Enhanced search functionality:** The website also incorporates an improve search feature to help users find relevant resources quickly.

AIDSInfo has also produced new versions, in English and Spanish, of the following fact sheets focusing on HIV/AIDS in these specific population groups:

- HIV and Children and Adolescents (Spanish)
- HIV and Women (Spanish)
- HIV and Gay and Bisexual Men (Spanish)
- HIV and Older Adults (Spanish)
- HIV and Drug and Alcohol Users (Spanish)

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Resources from Webinar on Trauma-Informed Care at ASOs
The National Center on Innovation in HIV Care has published the slide set from its May 25 Webinar on Trauma-informed Care at AIDS Service Organizations. In the webinar, Alex Keuroghlian of The Fenway Institute began with a review of recent research on the high prevalence of trauma- and stress-related disorders among persons living with HIV (PLWH). He cited studies indicating that approximately half of
PLWH experienced physical or sexual abuse during childhood, and that up to 90% report experiencing at least one severe traumatic event during their lifetime. Keuroghlian then discussed the ways in which trauma symptoms may lead to decreased engagement in HIV treatment and preventive services. He also described best practices in trauma-informed care that AIDS service organizations can implement to improve engagement of clients in HIV treatment and preventive services. These include: screening all PLWH for a trauma history; assessing persons who have a trauma history for post-traumatic stress disorder; educating patients or clients about trauma and HIV; making appropriate referrals to psychiatric, substance use, and social services; promoting resilience in trauma-informed care; and recruiting family and friends to provide social support for persons affected by trauma.

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New HIV Materials from CDC

During the past month, CDC has published several HIV reports, fact sheets, and HIV prevention campaign materials. These include:

**Diagnosed HIV Infection among Adults and Adolescents in Metropolitan Statistical Areas – United States and Puerto Rico, 2015** – This 88-page HIV surveillance report presents data on diagnoses of HIV infection during 2015 and on the total number of adults and adolescents living with diagnosed HIV infection at the end of 2014 who reside in metropolitan statistical areas (MSAs) – areas with a population of 500,000 or more – In the U.S. and Puerto Rico. “HIV programs may use this information to focus on populations and areas at greatest need for HIV prevention and treatment services, which is consistent with the High-Impact Prevention approach pursued by the CDC.”

**Behavioral and Clinical Characteristics of Adults Receiving HIV Medical Care – Medical Monitoring Project 2014 Cycle (June 2014-May 2015)** – This surveillance report, which consists of 29 slides, summarizes data gathered during the Medical Monitoring Project’s 2014 cycle (June 2014-May 2015) from more than 5,000 adults receiving HIV medical care in 23 project areas. It presents information about the demographic and socioeconomic characteristics of participants, as well as their coverage for HIV treatment, adherence, and status on the continuum of HIV care. Other variables covered include the use of gynecologic and reproductive health services and rates of high-risk sexual activity, sexually transmitted infections, depression, smoking, alcohol use, and recreational drug use.

**HIV Among Native Hawaiians and Other Pacific Islanders in the United States** (2-page fact sheet)

**HIV Among Asians in the United States** (2-page fact sheet)

As part of its “Start Talking. Stop HIV.” campaign to reduce HIV infections among gay, bisexual, and other men who have sex with men, CDC has also recently introduced new materials that feature men talking about HIV. These new resources include printed materials, web banners, and new videos, including:

- **30-second public service announcements**;
- **two-minute shorts** featuring in-depth conversations about HIV-prevention options; and
- **behind-the-scenes recaps** that share the stories of men who have participated in CDC’s HIV campaign.

CDC has also developed a [similar set of campaign materials](#) specifically for Spanish-speaking audiences.
FEATURED HEALTH RESOURCES

Materials for National HIV Testing Day (June 27)

National HIV Testing Day is an annual observance to promote HIV testing in the U.S. The 23rd annual HIV Testing Day will be held on Tuesday, June 27. The theme for the 2017 campaign is “Test Your Way, Do It Today!” To help you, your patients or clients, and at-risk communities prepare for and mark the day, we’ve compiled an annotated list of online resources focusing on HIV testing.

HIV Testing. Fact sheet from AIDSinfo with information about testing in a question-and-answer format. Also available in Spanish.

HIV Testing in the United States. Web page from the Kaiser Family Foundation.

HIV Testing. Fact sheet from AIDS InfoNet. Also available in Spanish.


Testing. Frequently asked questions about HIV testing from CDC. Also available in Spanish.

HIV Screening and Testing. Web page from the Centers for Disease Control and Prevention (CDC) with links to many resources, including guidelines for HIV testing in clinical and nonclinical settings, HIV laboratory testing and reporting of test results, and HIV testing of donors of organs and other tissues.

HIV Expanded Testing Initiative. Fact sheet from CDC.

GetTested: National HIV, STD, and Hepatitis Testing. CDC web page that includes a search feature to help people find nearby testing sites.

“I’m Doing It.” CDC has developed an extensive and growing body of materials for this HIV testing campaign, including videos, posters, palm cards, and banners featuring celebrities, community leaders, and volunteers.

Selected Recent Articles and Reports About HIV Testing

Changes in the Disparity of HIV Diagnosis Rates Among Black Women – United States, 2010-2014 (MMWR)

HIV Services Provided by STD Programs in State and Local Health Departments – United States, 2013-2014 (MMWR)


Health Care Use and HIV Testing of Males Aged 15–39 Years in Physicians’ Offices – United States, 2009-
2012 (MMWR)


HIV Testing Experience Before HIV Diagnosis Among Men Who Have Sex with Men – 21 Jurisdictions, United States, 2007-2013 (MMWR)

HIV Testing and Service Delivery Among Black Females – 61 Health Department Jurisdictions, United States, 2012-2014 (MMWR)

People with Severe Mental Illness Receive Insufficient HIV Testing (Poz)

“Serostatus Matters” Teaches Primary Care Docs About HIV Testing (Poz)

To Drive Gay Men to HIV Testing, Use Social Media (Poz)

What Are the Best Ways to Uncover Undiagnosed HIV Among Heterosexuals? (Poz)

Getting People HIV Meds the Same Day They Test Positive (Poz)

Grindr Reaches At-Risk Minority Gay and Bi Men with HIV Self-Testing Kits (Poz)

How Should HIV Self-Testing Services Be Provided? (AIDSmap)

World Health Organization Urges Scale-Up of HIV Self-Testing (AIDSmap)

Where Would Gay Men Prefer to Take Their Next HIV Test? (AIDSmap)

Market Constraints and Uncertainties May Limit the Scale-Up of HIV Self-Testing (AIDSmap)

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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, increase access to and retention in care and treatment, and attain and maintain desired health outcomes. Papers are listed alphabetically according to the lead author's last name.

Transition of Care for Youth with HIV. By M.E. Acree ME, in Pediatric Annals.

Adolescents with HIV and Transition to Adult Care in the Caribbean, Central America and South America, Eastern Europe, and Asia and Pacific Regions. By H. Bailey, M.L.S. Cruz, W.N. Songtaweesin, and T.
Puthanakit, in *Journal of the International AIDS Society*.

**Use of an Outreach Coordinator to Reengage and Retain Patients with HIV in Care.** By M.C. Bean, L. Scott, J.M. Kilby, and L.E. Richey, in *AIDS Patient Care and STDs*.

**High Rates of Access to Health Care, Disclosure of Sexuality and Gender Identity to Providers among House and Ball Community Members in New York City.** By S. Cahill, S. Trieweiler, J. Guidry, and others, in *Journal of Homosexuality*.

**Lessons Learned from the Implementation of Seek, Test, Treat, Retain Interventions Using Mobile Phones and Text Messaging to Improve Engagement in HIV Care for Vulnerable Populations in the United States.** By K.A. Christopoulos, W.E. Cunningham, C.G. Beckwith, and others, in *AIDS and Behavior*.

**90-90-90-Plus: Maintaining Adherence to Antiretroviral Therapies.** By J.B. Corless, A.J. Hoyt, L. Tyer-Viola, and others, in *AIDS Patient Care and STDs*.


**Real-World Strategies to Engage and Retain Racial-Ethnic Minority Young Men Who Have Sex with Men in HIV Prevention Services.** By T.E. Freese, H. Padwa, B.T. Oeser, and others, in *AIDS Patient Care and STDs*.

**Trends in HIV Continuum of Care Outcomes Over 10 years of Follow-Up at a Large HIV Primary Medical Home in the Southeastern United States.** By M.K. Ghiam, P. Rebeiro, M. Turner, and others, in *AIDS Research and Human Retroviruses*.

**A Flow-Based Model of the HIV Care Continuum in the United States.** By G.S. Gonsalves, A.D. Paltiel, P.D. Cleary, and others, in *Journal of Acquired Immune Deficiency Syndromes*.

**Using the Multiphase Optimization Strategy (MOST) to Optimize an HIV Care Continuum Intervention for Vulnerable Populations: A Study Protocol.** By M.V. Gwadz, L.M. Collins, C.M. Cleland, and others, in *BMC Public Health*.

**It’s a Process: Reactions to HIV Diagnosis and Engagement in HIV Care Among High-Risk Heterosexuals.** By A.H. Kutnick, M.V. Gwadz, C.M. Cleland, and others, in *Frontiers in Public Health*.

**A Mixed-Methods Exploration of the Needs of People Living with HIV (PLWH) Enrolled in Access to Care, a National HIV Linkage, Retention, and Re-Engagement in Medical Care Program.** By C. Maulsby, B. Enobun, D.S. Batey, and others, in *AIDS and Behavior*.

**Time from HIV Diagnosis to Commencement of Antiretroviral Therapy as an Indicator to Supplement the HIV Cascade: Dramatic Fall from 2011 to 2015.** By N.A. Medland, E.P.F. Chow, J.H. McMahon, and others, in *PLoS One*. Free full text also available.


Missed Initial Medical Visits: Predictors, Timing, and Implications for Retention in HIV Care. By A.E. Nijhawan, Y. Liang, K. Vysyaraju, and others, in AIDS Patient Care and STDs.


Primary Care and Hepatology Provider-Perceived Barriers to and Facilitators of Hepatitis C Treatment Candidacy and Adherence. By S.S. Rogal, R. McCarthy, A. Reid, and others, in Digestive Diseases and Sciences.


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.


Violence, Trauma, and Living with HIV: Longitudinal Predictors of Initiating Crystal Methamphetamine Injection Among Sex Workers. By E. Argento, S.A. Strathdee, S. Goldenberg, and others, in Drug and Alcohol Dependence.


The Changing Epidemiology of HIV in the Criminal Justice System. By J. Baillargeon, J.S. Pulvino, J.E. Leonardson, and others, in International Journal of STD and AIDS.


Decreased Odds of Injection Risk Behavior Associated with Direct Versus Indirect Use of Syringe Exchange: Evidence From Two California Cities. By C.N. Behrends, C.S. Li, and D.R. Gibson, in Substance Use and Misuse.


Cardiovascular Health in an Aging HIV Population. By F. Boccara, in AIDS.


Cocaine Use and Liver Disease are Associated with All-Cause Mortality in the Miami Adult Studies in HIV (MASH) Cohort. By A. Campa, S.S. Martinez, K.E. Sherman, and others, in Journal of Drug Abuse.


Impact of Aging on Neurocognitive Performance in Previously Antiretroviral-Naïve HIV+ Individuals on Their First Suppressive Regimen. By H. Coban, K. Robertson, M. Smurzynski, and others, in AIDS.


Disparities in HIV Knowledge and Attitudes Toward Biomedical Interventions Among the Non-Medical HIV Workforce in the United States. By R.M. Copeland, P. Wilson, G. Betancourt, and others, in AIDS Care.
Minority Stress Model Components and Affective Well-Being in a Sample of Sexual Orientation Minority Adults Living with HIV/AIDS. By R.J. Cramer, A.C. Burks, M. Plöderl, and P. Durgampudi, in AIDS Care.


Racial Differences in Prostate Cancer Risk in Young HIV-Positive and HIV-Negative Men: A Prospective Cohort Study. By A. Dutta, H. Uno, A. Holman, and others, in Cancer Causes & Control.


A Review of Risk Behaviors for HIV Infection by Men Who Have Sex with Men Through Geosocial Networking Phone Apps. By A.A. Francisco Luz Nunes Queiroz, Á.F. Lopes de Sousa, T.M. Evangelista de
Araújo, and others, in *Journal of Association of Nurses in AIDS Care.*

**The Duality of Oral Sex for Men Who Have Sex with Men: An Examination into the Increase of Sexually Transmitted Infections Amid the Age of HIV Prevention.** By T.R. Glynn, O. Operario, M. Montgomery, and others, in *AIDS Patient Care and STDs.*

**An Increased Rate of Fracture Occurs a Decade Earlier in HIV+ Compared with HIV- Men.** By A. Gonciulea, R. Wang, K.N. Althoff, and others, in *AIDS.*


**Gender Differences in the Path from Sexual Victimization to HIV Risk Behavior Among Homeless Youth.** By T. Harris, E. Rice, H. Rhoades, and others, in *Journal of Child Sexual Abuse.*


**Campus and Community HIV and Addiction Prevention (CCHAP): An HIV Testing and Prevention Model to Reach Young African American Adults.** By R.C. Holliday, T. Zellner, C. Francis, and others, in *Journal of Health Care for the Poor and Underserved.*

**Network Support, Technology Use, Depression, and ART Adherence Among HIV-Positive MSM of Color.** By I.W. Holloway, D. Tan, S.L. Dunlap, and others, in *AIDS Care.*

**Men Who Have Sex with Men Starting Pre-Exposure Prophylaxis (PrEP) Are at Risk of HCV infection: Evidence from the Amsterdam PrEP Study.** By E. Hoornenborg, R.C.S. Achterbergh, M.F. Schim Van Der Loeff, and others, in *AIDS.*


**Depression and Survival in a 17-Year Longitudinal Study of People with HIV: Moderating Effects of Race and Education.** By G. Ironson, C. Fitch, and R. Stuetzle, in *Psychosomatic Medicine.*


**The Societal Cost of Heroin Use Disorder in the United States.** By R. Jiang, I. Lee, T.A. Lee, and A.S.
Pickard, in *PLoS One*. Free full text also available.

**Facebook Advertising to Recruit Young, Urban Women into an HIV Prevention Clinical Trial.** By R. Jones, L.J. Lacroix, and E. Porcher, in *AIDS and Behavior*.

**Effectiveness of Nursing Student-Led HIV Prevention Education for Minority College Students: The SALSA Project.** By S.G. Jones, K. Chadwell, E. Olafson, and others, in *Journal of Health Care for the Poor and Underserved*.


**Mobile Text Messaging to Improve Medication Adherence and Viral Load in a Vulnerable Canadian Population Living with Human Immunodeficiency Virus: A Repeated Measures Study.** By E. King, K. Kinvig, J. Steif, and others, in *Journal of Medical Internet Research*.

**C-SAFE: A Computer-Delivered Sexual Health Promotion Program for Latinas.** By C.H. Klein, T. Kuhn, M. Altamirano, and C. Lomonaco, in *Health Promotion Practice*.

**Differing Experiences with Pre-Exposure Prophylaxis in Boston Among Lesbian, Gay, Bisexual, and Transgender Specialists and Generalists in Primary Care: Implications for Scale-Up.** By D.S. Krakower, N.C. Ware, K.M. Maloney, and others, in *AIDS Patient Care and STDs*.

**Physical and/or Sexual Abuse Is Associated with Increased Psychological and Emotional Distress Among Transgender Women.** By A.L. Kussin-Shoptaw, J.B. Fletcher, and C.J. Reback, in *LGBT Health*.


**Criminalizing Sex Work Clients and Rushed Negotiations Among Sex Workers Who Use Drugs in a Canadian Setting.** By A. Landsberg, K. Shannon, A. Krüsi, and others, in *Journal of Urban Health*.


Culturally Competent Sexual Healthcare as a Prerequisite for Obtaining Preexposure Prophylaxis: Findings from a Qualitative Study. By K.M. Maloney, D.S. Krakower, D. Ziobro, and others, in *LGBT Health*.


Comparison of Home-Based Oral Fluid Rapid HIV Self-Testing Versus Mail-in Blood Sample Collection or Medical/Community HIV Testing by Young Adult Black, Hispanic, and White MSM: Results from a Randomized Trial. By R.C. Merchant, M.A. Clark, T. Liu, and others, in *AIDS and Behavior*.


Factors Associated with Antiretroviral Therapy Adherence Among Transgender Women Receiving HIV Medical Care in the United States. By Y. Mizuno, L. Beer, P. Huang, and E.L. Frazier, in *LGBT Health*.


Attitudes Towards Exercise Among Substance Using Older Adults Living with HIV and Chronic Pain. By
A.L. Nguyen, J.E. Lake, M.C. Reid, and others, in *AIDS Care*.


**Syndemic Conditions and HIV Transmission Risk Behavior Among HIV-Negative Gay and Bisexual Men in a U.S. National Sample.** By J.T. Parsons, B.M. Millar, R.L. Moody, and others, in *Health Psychology*.

**Highly Successful Hepatitis C Virus (HCV) Treatment Outcomes in Human Immunodeficiency Virus/HCV-Coinfected Patients at a Large, Urban, Ryan White Clinic.** By M. Patel, S. Rab, A.G. Kalapila, and others, in *Open Forum Infectious Diseases*.


**The Differences Between Medical Trust and Mistrust and Their Respective Influences on Medication Beliefs and ART Adherence Among African-Americans Living with HIV.** By J.A. Pellowski, D.M. Price, A.M. Allen, and others, in *Psychology and Health*.

**The Association Between Residential Eviction and Syringe Sharing Among a Prospective Cohort of Street-Involved Youth.** By A. Pilarinos, M.C. Kennedy, R. McNeil, and others, in *Harm Reduction Journal*.

**Depression, Self-Esteem, and Childhood Abuse Among Hispanic Men Residing in the U.S.-Mexico Border Region.** By E. Provencio-Vasquez, H.J. Mata, J. Tomaka, and J.P. De Santis, in *Journal of the Association of Nurses in AIDS Care*.

**Quantifying the Harms and Benefits from Serosorting Among HIV-Negative Gay and Bisexual Men: A Systematic Review and Meta-Analysis.** By D.W. Purcell, D. Higa, Y. Mizuno, and C. Lyles, in *AIDS and Behavior*.


Health Literacy and Medication Adherence Among Patients Treated in a Free Health Clinic: A Pilot Study. By M.T. Sawkin, S.J. Deppe, J. Thelen, and others, in *Health Services Research Managerial Epidemiology*.


Viral Hepatitis C, Active Component, U.S. Military Service Members and Beneficiaries, 2008-2016. By S. Stahlman, V.F. Williams, D.J. Hunt, and P.O. Kwon, in *MSMR*.


Perceived HIV Prevalence Accuracy and Sexual Risk Behavior Among Gay, Bisexual, and Other Men Who
Have Sex with Men in the United States. By S. Sullivan and R. Stephenson, in *AIDS and Behavior*.

*Does the Combined Intervention Program Matter for College-Attending Hispanic and Other Minority Young Adults?* By T.S. Sunil, X. Xu, M. Mutchler, and F. Casanova, in *Journal of Health Care for the Poor and Underserved*.

HIV/AIDS and Academic Research Institutions-Consider a New Era. By K.D. Sydnor, in *Journal of Health Care for the Poor and Underserved*.


Provider Perceptions on HIV Risk and Prevention Services Within Permanent Supportive Housing. By S.L. Wenzel, B. Henwood, T. Harris, and others, in *AIDS Care*.


The Impact of Substance Use on Adherence to Antiretroviral Therapy Among HIV-Infected Women in the United States. By Y. Zhang, T.E. Wilson, A. Adedimeji, and others, in *AIDS and Behavior*.
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