COMMUNITY COMPASS
A PUBLICATION OF THE HIV VACCINE TRIALS NETWORK

FAITH & HIV
Welcome to the latest edition of the HIV Vaccine Trials Network (HVTN) Community Compass.

In this issue, we celebrate a recently launched scientific development leadership program under the direction of Dr. Alison Roxby, we revisit the critical role that language and effective community engagement plays in the COVID-19 response, and we recognize the very important role that faith has in many people’s lives and the critical role that faith communities have and continue to play in the HIV response. In this issue we also celebrate new hires Daniel Driffin and Kyle Gordon to the External Relations team, get an update on the activities of our HANC/Legacy Project partners, and catch an opinion piece on vaccine equity by our colleague Mitchell Warren, executive director of AVAC that was featured in the publication The Hill. We also must celebrate the amazing work that has went into developing the Red Ribbon Registry and the marketing campaign that accompanies it (which you can review by going to www.helpendhiv.org), and the amazing work that went into the refresh of our HVTN.org website. If you haven’t checked it out lately, I encourage you to do so!

The HVTN, including our partners and communities, played a monumental role in the response to COVID-19 through the work of the COVID-19 Prevention Network. We have, and continue to see, an unprecedented level of innovation in science and clinical trials, meaningful and cross-cutting engagement of communities and stakeholders, and resource allocation to support prevention and treatment options for COVID-19, as well as testing and other services. Though this pandemic has caused death and destruction, I also recognize the countless numbers of lives that have been saved through our collective efforts. It is truly historic and noteworthy, and a moment in which we can all take pride. While COVID-19 restrictions are shifting in many places, and many communities around the world have opened up, some places around the world have reverted back to mandatory masking and other restrictions. We must continue to acknowledge that the pandemic is not yet over, especially as we see diverse variants circulating that are being monitored for their potential to evade the immune responses created by our highly effective COVID-19 vaccines. We must continue the important discussions about the lessons learned during the COVID-19 pandemic that can be applied to HIV, and continue to stretch our thinking and expanding our hearts and minds to ensure that we are collectively moving in ways that do not leave people behind.

Finding a safe and effective HIV vaccine remains a key priority for the Network and our communities. Over the next couple of years, we will see many early phase studies launch which are focused on testing the safety of HIV vaccine candidates and exploring other strategies to vaccine development. These studies are in smaller numbers of people; however, we do have one large scale HIV vaccine study that is still active, Mosaico (www.mosaicostudy.org), and we are looking forward to seeing results in the near future. This study uses a mosaic-based platform which supports the evaluation of the vaccine across various types of HIV found around the world.

As we continue onward in our effort to find a safe and effective HIV vaccine, a few questions continue to come up in my conversations with stakeholders including, “how did we get a COVID-19 vaccine within one year but we are 40+ years into HIV and have not come up with a viable vaccine?” This is such an important question, and truly my response cannot be overstated. HIV and SARS-CoV-2 are very different viruses, with HIV developing a tremendous number of variants, which makes it a constantly moving target. One thing we learned from the COVID-19 trials is that investments in rapid iteration of trials reap early benefits – and this is even more important as we refocus attention on an HIV vaccine. Whenever these or other questions
are asked, I feel a sense of gratitude and appreciation that people remain concerned about this disease and finding an HIV vaccine.

Please help us ensure that this publication is representative of our entire global HVTN community! HVTN members (who have access to the HVTN member’s website) can use our submission page that offers the ability to submit content and articles for inclusion in future issues. More information about this follows on the “Meet the Community Compass Team” section.

Thank you for your continued support of the HVTN wherever you are in the world, for the work that you do in whatever role you have in the HVTN community, and for the impact we have been able to make in our collective history and communities, together. Though we have come very far in response to the HIV epidemic, we have so much further to go to achieve a globally effective HIV vaccine. The HVTN Community Compass team wants to be everywhere you are, so please share with us what’s happening at your research sites, institutions, and in your communities, so that we can share it with the world.

Be well,

Stephaun E. Wallace
Stephaun E. Wallace, Ph.D.
Editor-in-Chief, HVTN Community Compass
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Our vision is an informed HVTN community that is aware of current events and activities relating to the HVTN network and its sites, advances in the field of HIV prevention and vaccination, as well as community priorities. We work to accomplish this by providing relevant information and updates to promote awareness, understanding, and support for HIV prevention and HIV vaccines, reaching global communities invested in the response to the HIV epidemic.

We welcome submissions of articles on any topic for publication that is relevant to the HVTN community. Submissions must be exclusive to us, and not appear in any other publication. Submissions must be 500 words or less to comply with our layout and design requirements. Due to space limitations, we may need to hold publishing your article for a future issue.

To submit articles for Community Compass, please go to the HVTN Members Site homepage, click on “About”, then click “Community Compass”, then click on “Submit to Community Compass”.

Meet the COMMUNITY COMPASS Team

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Connecting My Faith and HIV/AIDS

By: Gail B. Broder, MHS, HVTN Core, Seattle, WA, USA

What does the Torah say about HIV and AIDS? Is there a Jewish response to HIV/AIDS? What are the Jewish beliefs about HIV prevention and treatment? And what about political issues such as abstinence-only education in schools, and federally funded needle exchange programs? Is there a Jewish way to respond to these political issues? What guidance does my religious tradition, Reform Judaism, offer?

These were the kinds of thoughts rattling around in my mind throughout the late 1980s and the 1990s. I had started to experience the losses of friends, mostly gay men whom I knew through my music circles. Then I lost a dear mentor and teacher just six weeks after he told people that he had been diagnosed with AIDS. That was the catalyst that pushed me toward graduate school and changing my career path to work in HIV prevention.

My rabbi at that time invited me to attend a meeting with her, a formative meeting to consider whether there was interest to form some kind of city-wide Jewish community group to address the HIV/AIDS epidemic. Ultimately, the St. Louis Jewish Task Force on AIDS was formed. My rabbi served as chairperson for a few years, and later I became the first lay leader to serve as chairperson. We tackled issues like burial practices for the Jewish funeral homes and cemeteries, we encouraged congregations to march in the annual fundraising walk, and we hosted a range of educational forums.

During this time I enrolled in graduate school, and started working on my thesis. Ultimately my thesis work formed the basis for a multi-session curriculum in HIV prevention education that was specifically directed to the Jewish community, and I pilot tested it in several St. Louis congregations. I created a text study using texts from the Torah (also known as the Old Testament), Talmud (a collection of Jewish oral history), and other sacred writings. The curriculum included opportunities for parents and teens to go through the program together, learning the same information in separate classrooms for kids and adults. The program culminated in service projects that families did together, including home meal delivery to people living with HIV, and visiting with the residents of an extended care facility that specifically served people living with HIV. Learning the same material meant that families could have discussions at home about what they were learning, with everyone on equal footing. They were learning the vocabulary of sexual health, how to talk about sex and prevention as normative human behaviors and not something to get squeamish or prudish about.

I remember speaking to a class of 7th graders at their religious school one Saturday morning, kids about 12 or 13 years old. Their rabbi was in attendance, sitting in the back of the room. This was something I required; kids needed to know that it was OK to have these conversations with their clergy, and that the synagogue was a safe place to discuss sexual health. I told the class to be sure to stop me if there were words I used that they didn’t understand, or if they had any
questions. And sure enough, not 10 minutes into my presentation, the first hand went up. “What’s oral sex?” The first part of my brain thought, oh, that’s so sweet that you’re naïve and don’t know. The next part of my brain thought, oh, you’re going to go home and tell your parents you learned about oral sex at religious school! And meanwhile, the rabbi in the back of the room was looking at me wide-eyed with an expression that said, “This is all on you; don’t expect me to help you here!”

So I looked at the student and answered, “Oral sex means that you use your mouth to give someone sexual pleasure.” The student looked back at me, and said, “Oh, that makes sense. Thanks.” The rabbi looked stunned – was it really that simple?

It is, and it continues to be. Together, students and parents learned about the Jewish values of saving a life (and sometimes you have to save your own life); of all Jews being responsible for each other, often known as “I am my brother’s keeper”; of visiting the sick without concern for the cause of their sickness; and the idea that all human beings are created in the image of the Holy One and are therefore equally sacred, combatting stigma head-on. We learned about passages of the Torah that could be applied to contemporary situations, like the lessons about leper colonies that had to be separated from the rest of the community, and how that kind of stigma continues in our own time. We learned about our forefather Jacob and his two wives, his two concubines, their use of mandrakes as an aphrodisiac, and the births of 13 children: clearly there was some unprotected sex happening back then! Giving people the opportunity to learn and grow, to ask questions in a safe place knowing that they will not be shamed for their naivete, continues to be the work that moves and inspires me.

In recent years, and following my move to Seattle, this same kind of work has expanded to my involvement in the Jewish community around the legalization of gay marriage, and working to make Jewish congregations inclusive for lesbian, gay, bisexual and transgender people. It turns out that Judaism has a lot to say on those issues too!

One of my favorite quotes from Rev. Dr. Martin Luther King, Jr. that doesn’t often get heard is posted on the bulletin board in my office: “Science gives man knowledge, which is power. Religion gives man wisdom, which is control. Science deals mainly with facts; religion deals mainly with values. The two are not rivals.” And one of our Jewish sages, Rabbi Tarfon, is quoted in the Talmud, “The day is short, the task is great...You are not required to complete the task, but neither are you free to neglect it.” These words from great men of faith continue to inspire me every day, and have helped me connect the dots between my faith tradition and my work, and just how important it is that the two work hand in hand.

Gail Broder is the Associate Director of Social and Behavioral Sciences and Community Engagement for the HVTN.
Faith Initiative Expands to Help Build Bridges Between Community and HIV Vaccine Trials

By: Anna Altavas, HVTN Core, Seattle, WA, USA

SEATTLE — DECEMBER, 14, 2021 — While the rapid development of effective vaccines has helped combat the COVID-19 pandemic, key communities – especially people who are living with HIV – remain disproportionately impacted, and are at higher risk of severe disease and death. Finding an effective HIV vaccine is critically important, and to that end, the HIV Vaccine Trials Network (HVTN) is launching an expanded Faith Initiative that will help advance the work of finding a cure.

The national program involves faith ambassadors across the country who will meet and engage with people where they are, focusing on enhancing trust and providing accurate and updated information about HIV and HVTN clinical trials.

More than 20 years ago, when the HVTN was first established, engaging communities in clinical trials through partnerships and collaborations with faith communities has been a focal point in its mission. As part of the HVTN’s commitment to continue to meet communities where they are, engaging and maintaining relationships with faith communities has been a critical function of the HVTN’s work.

With the emergence of COVID-19, the HVTN and three other existing clinical trials networks merged to form the COVID-19 Prevention Network (CoVPN) to enroll thousands of volunteers for large-scale Phase 3 clinical trials testing a variety of investigational vaccines and monoclonal antibodies to protect people from COVID-19. Reflecting HVTN’s example of the importance of community engagement in HIV clinical research to build bridges of understanding between faith and HIV science, the CoVPN implemented a robust community engagement strategy that featured a formal Faith Initiative to engage people of faith around COVID-19 education.

"The faith ambassadors, trusted within their communities and having long-term relationships with the scientists in the research networks, helped bridge gaps that existed by assuring their communities that participation in the clinical trials is the best way to ensure that study results accurately represented the entire population and are effective for all people," said Rev. Edwin Sanders, Senior Servant at Metropolitan Interdenominational Church in Nashville, Tennessee, and long time partner of the HVTN, who has served as the centerpiece of the HVTN Faith Initiative over the years.

Under the leadership of Rev. Sanders, the CoVPN Faith Initiative reached millions of people with COVID-19 information and
education that helped communities move from COVID ignorance to COVID competency; from vaccine hesitancy to vaccine acceptance and accessibility; and from medical mistrust to medical accountability and reconciliation. The success of the CoVPN Faith Initiative has paved the way for the expansion of the HVTN Faith Initiative that leverages the expertise and community capital of eight diverse and geographically distributed HIV, public health and faith practitioners (ambassadors), who integrate anti-racist, anti-xenophobic, anti-homophobic and good participatory practice principles into a faith framework undergirded by science and stories.

“Through conducting inclusive community education and recruitment efforts to ensure that the most impacted communities are included in COVID-19 clinical trials helped establish effective vaccines that served all of the populations that most needed it,” said Dr. Stephaun Wallace, Director of External Relations, CoVPN/HVTN, at Fred Hutchinson Cancer Research Center. “We hope through the expansion of the HVTN Faith Initiative, we can find success like we did with COVID-19 and ultimately develop a vaccine that can help people globally.”

UBtheCURE LLC, a Chicago-based consulting company operating at the intersection of faith, health and human rights, will direct the HVTN Faith Initiative under the leadership of CoVPN Faith Ambassador and HVTN partner, Dr. Ulysses Burley III. UBtheCURE will build upon the successful model of the CoVPN Faith Initiative to expand the HVTN Faith Initiative with the overarching purpose of increasing awareness of the impact of HIV/AIDS in the United States and the prospect of HIV vaccine development, while continuing to address the ongoing COVID-19 pandemic and other existing and emerging health challenges that disproportionately impact BIPOC communities, which include people of faith.

When asked about the significance of leading this initiative in this moment in history, Burley said, “Faith — much like scientific research — is rooted in the desire for abundant life for all, with healing as a key tenant in every sacred text. 40 years into an HIV epidemic that has claimed 40 million lives, with nearly 40 million people currently living with HIV, even a marginally effective HIV vaccine would prevent millions of new HIV transmissions, saving millions of lives. Therefore, the active pursuit of an effective HIV vaccine that can bring wellness and wholeness to the world is not just theoretical, but it’s theological as well. It only makes sense that the faith community is an active partner in any endeavor to heal the masses, be it through partnerships like the HVTN Faith Initiative, or the CoVPN Faith Initiative. When we commit, not just to the science, but also to the sacred — we can shift the conversation from being just about information, to one that’s about transformation.”

To learn more about the HVTN and its community engagement strategy, visit www.hvtn.org.

Anna Altavas is the Communications Manager for the HIV Vaccine Trials Network and COVID-19 Prevention Network.
Ending the HIV Epidemic: Faith and HIV – Buddhist Perspective

By: Eric Reece, MSW, HVTN Faith Ambassador

Four decades.

OVER four decades of the HIV/AIDS pandemic.

Over four decades and still we combat the detrimental lack of sexual health education in many parts of the world, and specifically in the Southern US where I live.

Four decades of witnessing the harrowing, disproportionate impact on the lives of Black and Brown people, and our families and loved ones.

AND four decades of continuous oppressive stigma that feeds the lack of affirming medical care and builds barriers to evidence based prevention methods as well as the basic tools WE KNOW will truly end this pandemic: stable housing, meaningful employment with a living wage, and increasing affirming emotional wellness and healing.

Over four decades of this pandemic.

Yet, in these more than four decades, we have learned, we have grown, and most wonderfully, we still have hope, hope that is grounded in faith. In my faith practice, Nichiren Buddhism, we hold the value that with all the despair, hurt, and pain these four decades have caused, WE still have the ability to change the “poison of despair into medicine.”

The essence of Buddhism is the conviction that we each have within us the ability to overcome any problem or difficulty that we may encounter in life. This inherent potential is what we refer to as the Buddha Nature -- a state of life characterized by limitless courage, wisdom, and compassion. The founder of Buddhism, Shakyamuni, or Siddhartha as he is sometimes known, expressed this law in the Lotus Sutra, where he revealed that ALL people WITHOUT exception, possess this Buddha nature and are inherently worthy of respect.

For me, the blessing/benefit – YES, BLESSING/BENEFIT -- of these over four decades is the rise of faith communities who provide better support for people living with HIV. Faith communities that support comprehensive sexual health education; faith communities that even provide linkage to treatment and care; and yes, faith communities that take action to eliminate stigma around HIV. Each one of us can become aware of our Buddha Nature and form or join faith communities -- to change poison into medicine!


A Bahá’í Faith Perspective

By: W. Imara Canady, HVTN Faith Ambassador

The harmony of science and religion is one of the fundamental principles of the Bahá’í Faith. Bahá’ís reject the notion that there is any inherent conflict between science and religion. Given this key aspect of the teachings of the Bahá’í Faith, I believe that there is a direct connection to the role of science within the faith lens, particularly as we look at recent vaccinations around COVID-19 and the evolution of HIV vaccine research.

The intersectionality of faith and science is exhibited throughout the Writings of the Bahá’í teachings, where there are myriad writings that provide guidance for the global Bahá’í community regarding the need for and use of vaccinations. When our global community was challenged with questions around COVID vaccinations, the governing body of the United States Bahá’í Community issued the following guidance: “In relation to the coronavirus pandemic, the friends should follow the counsel of medical and other scientific experts on . . . the wisdom of particular health measures.” As an individual believer, I would offer that as HIV vaccines eventually become available to our community, this guidance would likely be shared with all of those affected by HIV.

However, as scientists continue the development of HIV vaccines, we continue to experience a constant evolution in the very foundations of how we operate as a “global community.” As this shift occurs, I would suggest that there is another public health issue that points to the intersectionality of these two areas, and that is the issue of discrimination. Though discrimination can be exhibited in many ways, I will focus on discrimination against those living with HIV. One critical teaching of the Bahá’í Writings is the elimination of prejudice and judgment of any kind, and the reality of the oneness of humanity. This also speaks to the connection between science and religion. To me, these two realities
that, hopefully, we are all working to embrace in our own lives are some of the most powerful depictions of the connection between science and faith.

While those in the areas of science and public health continue to do life-saving work around addressing HIV, it is critical that we who profess to be people of faith, no matter what that spiritual path may be, do the daily work of eliminating our individual and societal biases against any human being living with HIV. Our faith communities should be safe places for all, and encouraging spaces to ensure the full health and well-being of all believers. I would close by suggesting that as faith leaders follow the science on the evolution of all vaccines, we must also embrace the scientific and spiritual basis of the unity in our diversity and the oneness of all humanity, without regard for HIV status.

**The Intersection of Faith and Science**

By: Dr. Donta Morrison, Ph.D., HVTN Faith Ambassador

Since the onset of COVID-19, I have witnessed the distress caused by the religious/scientific divide as it pertains to prevention (including vaccines) and treatment created to combat the virus. Creating a healthy intersection between science and faith is a process laden with variables. Whereas science is based upon reason and observation, religion is the belief in and worship of a superhuman controlling power, especially a personal God or gods. Contradictions between the two significantly stress efforts designed to bridge gaps that could improve the living conditions of all individuals. Understandably, persons of faith rely on their connection to and relationship with God to guide them through various phases of life. Regardless of what may be the best practical or scientific action, if it does not align with someone’s belief practice, many will bypass rational thought and hold fast to supernatural hopes of healing and restoration. This can be problematic when the avoidance of proven scientific strategies can affect the health and well-being of an entire populace.

Despite the obvious differences in approach, both have a common goal: to provide best practices for survival. However, when it comes to issues about health and wellness, those on the cusp vacillate between scientific findings sustained by facts and spiritual teachings about the will of God. The latter can be risky if time is of the essence. If we recall, in the early years of AIDS, gay men were publicly demonized by religious communities and told that their sickness was God’s will. Despite scientific research disputing all myths and misconceptions, 40 years later we are still chopping down the trees that sprouted from those negative seeds. Hence, we are still discussing the importance of developing strategies that will establish camaraderie and mutual respect between faith and scientific communities.

The process of synergizing these efforts can be furthered by those with a balanced appreciation of scientific and religious attitudes toward wellness. As one who both serves in ministry and trusts scientific research, I understand that educational approaches must be respectful and careful not to devalue either view. It is important that faith communities be made aware of scientific advances, and that researchers recognize the role faith plays in the lives of many people. Neither should be abased. I believe we are in the perfect season to create spaces that will leverage conversations, and introduce a method of engagement, that respectfully shows how God can be in all things.

**The Body of Christ has HIV**

By: Dr. Ulysses W. Burley III, M.D., MPH, HVTN Faith Initiative Director

“Going down?” I asked as I stepped onto an elevator already occupied by a few of my future colleagues. I had just signed a contract to implement and direct the HIV/AIDS strategy for a major mainline Christian denomination with a focus on the United States. In my first of many elevator speeches over the next couple of years, I introduced myself and my new role as director of the HIV/AIDS strategy, and I was received with welcome and enthusiasm, and a peculiar yet sincere question:

“How’s HIV going in Africa?”

In a single elevator ride it was already clear to me that my task to educate,
elevate awareness, and eradicate stigma among American Christians regarding the U.S. HIV crisis was beyond great. That was almost a decade ago. 41 years into the epidemic and many people still believe HIV is a disease relegated to the continent of Africa, including people of faith.

Indeed, in 2021 nearly 26 million of the more than 37 million people living with HIV worldwide were in Africa. Likewise, the World Health Organization (WHO) estimates that 40% of health care delivery in Sub-Saharan Africa is delivered by Christian clinics, hospitals, and community health centers. Christian Missionaries were among the first to invest in modern medicine in Africa and have historically had conflicting effects on the HIV epidemic there. American Christians have long been eager and willing to financially support efforts to combat the HIV epidemic in Africa through local churches with global ministries.

Yet U.S. faith leaders and congregations are often not well informed or connected to public health efforts for HIV and AIDS here at home. On one hand, the United States finds itself in the similar company of countries in Africa, in that the epidemic in the U.S. predominates in poor and African Descent communities. On the other hand, over half of the people living with HIV in Africa are women and girls, whereas the majority of new HIV infections and people currently living with HIV in the U.S. are among men who have sex with men, and women of trans experience. It’s perhaps this contrast that has attracted U.S. churches to HIV advocacy abroad as opposed to making intentional connections with local efforts.

Consider the long yet tenuous relationship between Christianity and HIV/AIDS. The intersection of sex and sexuality with HIV and AIDS has presented some sectors of Western Christianity with a ‘moral’ dilemma. As the disease has disproportionately impacted the LGBTQIA+ community in the United States, supporting women and girls impacted by HIV halfway around the world becomes more palatable and less confrontational than supporting the same-gender-loving man secretly living with HIV in our own choir stands. The former reality affirms the Christian call to welcome the stranger, heal the sick, and bless the poor which makes us feel good; the latter challenges our belief that the face of this potentially deadly virus is sickly, poor, and foreign when in fact the faces of HIV are among us, hiding in plain sight.

It’s no coincidence that the region of the United States that accounts for the largest population of Black and LGBTQIA+ Americans with the highest prevalence of people living with HIV is also the region of the country with the highest confluence of Christian churches – the U.S. South, also known as the ‘Bible Belt.’ It’s not to say that Christianity is the cause of the disproportionate impact of HIV on people in the southern United States - that would be an unfair and unfounded claim of causation. However, there is a correlation that we cannot ignore: the past silence of Christian churches in the fight to end HIV in the U.S., and the Church’s refusal to name sex and sexuality as a God-given part of the human experience, has helped create a closet of secrecy and shame that stigmatizes those most vulnerable to HIV.

HIV-related stigma now kills more people than HIV. We are at a point in the epidemic’s history where we have science and medicine to prevent HIV transmission and effectively treat people living with HIV, but stigma and discrimination still prevent vulnerable populations from accessing the scientific and medical breakthroughs that would benefit them most. What we need now in order to end HIV as a public health crisis in the U.S. is to treat people, and not just disease. We cannot get there without the advocacy of the largest faith community in the country, because the body of Christ has HIV.

First Corinthians, chapter 12, verses 12-31, says:

(12) For just as the body is one and has many members, and all the members of the body, though many, are one body, so it is with Christ... (14) Indeed, the body does not consist of one member but of many... (19) If all were a single member, where would the body be? (20) As it is, there are many members yet one body. (21) The eye cannot say to the hand, “I have no need of you,” nor again the head to the feet, “I have no need of you.” (22) On the contrary, the members of the body that seem to be weaker are indispensable, (23) and those members of the body that we think less honorable we clothe with greater honor, and our less respectable members are treated with greater respect, (24) whereas our more respectable members do not need this. But God has so arranged the body, giving the greater honor to the inferior member, (25) that there may be no dissension within the body, but the members may have the same care for one another. (26) If one member suffers, all suffer together with it; if one member is honored, all rejoice together with it.

People living with and affected by HIV and AIDS include members of the U.S. church body and people of faith and goodwill around the world. When one member of the body of Christ suffers, the rest of the body suffers with them. The good news is that an awakening is certainly happening, with Christians
and other people of faith at the forefront. The mere existence of the HVTN Faith Initiative is a testament to how far we've come by faith. If we are to end HIV as a public health crisis by 2030, our understanding of the U.S. HIV epidemic and our role in responding to it must go beyond elevator speeches to become sermons and ministries that service the local church and community.

As a follower of Jesus Christ, I’m proud to lead the U.S. HVTN Faith Initiative alongside my multifaith brothers and sisters to honor even just one member of the body, so that we might ‘all rejoice together with it.’

Faith Community Engagement – A Latinx Muslim Perspective

By: Sultana Ocasio, HVTN Faith Ambassador

The inclusion of faith communities in evidence-based health education is crucial in improving quality of life and also for the preservation of life, an important value in many faiths. Faith communities and the faith-observant can often be viewed as resistant to evidence-based or scientifically backed information. On the contrary, the faith-observant view life and make choices not by opposition to science, but through a lens guided by their faith and how they identify as observers of the faith. By respecting and honoring that, and engaging with faith communities in their spaces, health educators are invited, welcomed, and received as subject matter experts who can remove barriers created by misinformation. When dialogue begins, myths are dispelled.

Though discussion of HIV in many faith communities can be difficult to navigate, individuals who are trusted can be the gatekeepers to access sacred spaces. Mutual trust and respect are key components to engaging in HIV education and de-stigmatization efforts in faith communities. The subject matter experts must be trusted, and the dignity of the faith community must be preserved by the health experts.

Some of the most important values in Islam are preservation of dignity, sanctity of private life, and benefit to the community at large. My work in Muslim communities has illuminated the need for and the efficacy of faith-based approaches to HIV education. These efforts honor and create capacity for inclusion into sacred spaces for our sisters and brothers living with HIV. We know that whatever affects the majority, also affects the minority. Black and Latino communities are disproportionately affected by HIV, which is true for the faith-observant as well. I continue the work of Latin and Black Muslims who have used Islamic values to create impact in their communities, and who have created the legacy of a bold and untethered approach to effect change.

Likewise, as a Latina, working within the Latino community with people of all faiths allows me to reach a population disproportionately affected by HIV. Working with non-Latino Muslim communities, particularly those from Muslim majority countries, allows me to reach communities that are further at risk because of a perception or denial that HIV poses a risk to them.

Bringing HIV education into faith communities is especially important for the faith observant, as they may not seek education and resources outside their faith communities. Discussion, dialogue, and education about HIV in faith communities also allows space for faith observers who are living with HIV. For those of us living with HIV, connection with faith and the divine are essential for health and well-being. The more we destigmatize the conversation, the more inclusive our sacred spaces become, and the more whole we become as individuals and communities. Inshallah.

“Tie your camel first, and then put your trust in Allah”

By: Khadijah Abdullah, HVTN Faith Ambassador

Faith plays an integral role in the lives of many Americans across the United States, and even more so in minority communities. Growing up in the Black and Latino community, I’ve witnessed firsthand the impact of faith on these populations. Visiting Latino friends, I would see candles representing various saints around their homes, the prominent presence of a cross on their walls, and many references of God during conversations.

I also grew up with my Black grandmother who was a prominent figure in her church, and God was incorporated into every aspect of her life. The same was true for my aunts and other extended family members. Within my own home, I was exposed to the diverse teachings of Islam and attended a mosque/masjid in my community that supported a melting pot of populations. Being exposed to these rich and beautiful cultures of mixed faiths and backgrounds helped me to develop a unique perspective on life.

I also grew up around discussions of vaccine hesitancy or distrust of science and medicine, and how faith alone could be an option to stay healthy. Our relationship with...
Faith Ambassador Perspectives

Faith Matters: A Personal Reflection

By: Dr. Bambi Gaddist, DrPH, HVTN Faith Ambassador

Like no other time in the history of our nation, the faith community once more stands at the crossroads. We must let the world know which side of the fence we are standing on, as it speaks to our calling for love and compassion. Houses of worship, whether brick and mortar or street outreach, can serve as the foundation for truth as we struggle to combat myriad health disparities in the Black community. Our community has, and will continue to, confront catastrophic suffering and loss of life throughout congregations if we are unclear about what pathway we are traveling. Is it a path of science or fiction?

If we would reflect for a moment on Dr. Martin Luther King’s "Letter from Birmingham City Jail", penned on April 16, 1963, we would take to heart his call of intergenerational agreement. Where does our faith come in as we struggle to combat injustice? How will people of faith intervene? How will people of faith actively reengage our fight against complacency as civil rights -- that we thought were secure -- seem likely to vanish without a trace. The faith community historically did matter and must continue to be a vital part of the vision needed to salvage what civil rights remain.

Similarly, communities of faith stand at the intersection of civil rights and access to life-saving health care. At this very moment, let us call upon the names of every ancestor who fought and died for current privileges we too often take for granted. Let us recommit our voices of faith and decide how we can actively play a part in translating truth to believers and those who seek spiritual peace.

People of faith have and continue to lose life due to COVID-19 and other health disparities. As such, let us draw upon our collective power within and throughout houses of faith to counteract fear and stigma that led to so many premature deaths.

Let us embrace every opportunity to fight disinformation and misinformation, and bring lifesaving therapies to those we profess to love and shepherd. Now more than ever, given the devastation caused by health disparities among people of color, is it not our moral responsibility to ensure that information communicated to our families and communities comes from trusted sources grounded in science and truth, not personal opinion and conjecture?

As believers in a higher source, we have a rare opportunity right now to be a part of the solution to life, not the problem, for it is certain that we can’t save a soul if they lose their life “way to soon.” Let us explore how we may become a new conscience of the community. We will accomplish this through our compassion and ability to do the Creator’s work, because communities will see in us that “Faith Matters.”

trust in science was complicated, and not many within my community were interested in marrying or developing a lifelong relationship with it. Over the years, I witnessed my grandmother die from a heart attack, my aunt spend years in a coma due to complications from an asthma attack, and other family and friends die from preventable or treatable diseases. It made me question science a little less, even though I still had a heavy distrust of many vaccines.

My journey has empowered me, and helped me to navigate my own path when it came to understanding vaccine science and peeling back the layers of medical distrust. I also realized I can still have a deep relationship with my faith and also trust science. In the Islamic faith, there is a religious saying that is traced back to our Beloved Prophet Muhammad (peace and blessings of God be upon him) that says: "Tie your camel first, and then put your trust in Allah." In essence, this means that faith is a great way to have a relationship with God and trust in Him, but also use the tools God has given you. Tie up your camel to help ensure it doesn’t wander away while unattended, then you trust in God that it will still be there when you return. This is the same reflection I take when it comes to medicine and science. I’ll take the necessary steps to be healthy and then leave the rest in God’s hands.

With this outlook, I am honored to be a part of the HVTN Faith Initiative team, and I hope my faith, relationship with God, and open willingness to embrace science can have a positive impact on the communities I serve.
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*Applicable to US residents only
New Scientific Leadership Development Program Launches

By: Alison C. Roxby, MD, MSc, HVTN Core, Seattle, WA, USA

Valeria Cantos, M.D.

Dr. Cantos is an infectious disease specialist and since 2017 she has been a clinician and co-investigator at the Emory University Ponce de Leon clinical research site in Atlanta, Georgia. She has served as co-investigator for several HVTN studies, including HVTN 137, HVTN 706 (MOSAICO), and HVTN 704 (AMP study). She has also served as lead site investigator for several inpatient and outpatient COVID-19 studies, as well as scientist-led HIV prevention projects. Dr. Cantos is the lead investigator for the Community Engagement team at her site. She is invested in optimizing representation of Latinx and Black populations in HIV vaccine and prevention clinical trials.

Mentor: Colleen Kelley, M.D., M.P.H., Emory University School of Medicine

Jorge Gallardo, M.D.

Dr. Gallardo-Cartagena is a junior investigator at the Centro de Investigaciones Tecnológicas, Biomédicas y Medioambientales (CITBM) of the Universidad Nacional Mayor de San Marcos (UNMSM) in Lima, Peru. After completing his residency training in Infectious Diseases in 2017, he joined the PERU CTU and started working in HVTN trials as a study physician and sub-investigator at the Barranco CRS. In early 2018, he was appointed as HVTN Clinic Coordinator and CRS Coordinator, being in charge of the operational aspects of the HVTN 704/HPTN 085 (AMP) protocol implementation. Since 2019, he was designated Investigator of Record for the HVTN706 (MOSAICO) and CoVPN3003 (ENSEMBLE) protocols at the CITBM-UNIDEC CRS. He is also serving in the HVTN Network Evaluating Committee and the HVTN 804/HPTN 095 Protocol Team as a Consulting Investigator.

Mentor: Jorge Sánchez, M.D., M.P.H., PERU Clinical Trials Unit

Portia Hunidzarira, M.B.Ch.B., M.Sc.

Dr. Hunidzarira has been the Clinical Research Site Leader at the Seke South CRS in Harare, Zimbabwe, since 2015. In that time, she has served as an investigator on HVTN 107 and 120, as well as the site Investigator of Record for HVTN 703 (AMP study) and the site Principal Investigator for HVTN 705 (Imbokodo). Dr. Hunidzarira has also been active in other networks, including the MTN with trials of the Dapivirine ring, and is involved in CoVPN protocols at the site (CoVPN5001, HVTN405/HPTN1901, and CoVPN3008). She also received a Master’s degree in Public Health from the London School of Hygiene and Tropical Medicine. Her mentor noted that she works closely with at-risk populations, community activists, and CABs as part of her leadership. She also serves as a member of the HVTN Scientific Governance committee and the HVTN Scientific Review Committee.

Mentor: Z. Mike Chirenje, M.D., F.R.C.O.G., University of Zimbabwe Clinical Trials Research Centre

Dr. Alison Roxby is the Director of Scientific Mentoring for the HVTN, and Associate Professor, Departments of Medicine and Global Health at the University of Washington, Seattle, WA.
Hello HVTN colleagues!

I am very pleased to announce the inaugural awardees under the HVTN’s new Scientific Leadership Development program. This program identifies mid-career scientists who would benefit from additional resources and mentorship on their way to becoming leaders in the field. This program also has a solid commitment to ensuring that our clinical trials are led by people from the communities which we serve. This year’s cohort of awardees has been selected by the Scientific Capacity Building Working Group. Please read their stories below.

Rachel Kawalazira, M.B.B.S., M.Sc.

Dr. Kawalazira has been a Principal Investigator since 2021 and Study Coordinator and Medical Officer since 2014 at the Johns Hopkins Research Project in Blantyre, Malawi. In that time, she worked on IMPAACT 2008, a study of monoclonal antibody VRC01 in infants with HIV under 3 months of age, and is currently serving as Study Coordinator for HVTN 805, an analytical treatment interruption study for HIV-infected individuals who participated in the AMP study (HVTN 703). She is serving as a local Principal Investigator on a phase 3 efficacy and safety trial of an oral PrEP drug called Islatravir. Dr. Kawalazira has a degree in Vaccinology and is focused on HIV vaccine research to improve the HIV burden in her setting and globally.

Mentor: Johnstone Kumwenda, M.B.Ch.B., M.Sc., F.R.C.P., Kamuzu University of Health Sciences (Formerly, College of Medicine under University of Malawi)

Pamela Mda, M.B.Ch.B., M.Med.

Dr. Mda has led the Nelson Mandela Academic Clinical Research Unit in Mthatha, South Africa since 2017. Dr. Mda’s leadership has enabled a strong research site in a remote, rural area of South Africa. At Mthatha, Dr. Mda revitalized the site and catalyzed successful trials, serving as investigator on HVTN 405, HVTN 702 (Uhambo) and HVTN 705 (Imbokodo). She is site PI for CoVPN studies including CoVPN 5001 and 3008. Dr. Mda is an expert clinician and played a major role in training health care workers for ART rollout in the Eastern Cape, South Africa, and has continued as a leader in Covid-19 education, prevention, and vaccination in her region. She also contributes as a clinician educator for the medical students and medical officers at Walter Sisulu University/Nelson Mandela Academic Hospital.

Mentor: Glenda Gray: M.B.B.CH., F.C.Paed., D.Sc., President and CEO of the South African Medical Research Council

Deborah Theodore, M.D.

Dr. Theodore has been a site investigator at the Columbia Physicians & Surgeons Clinical Research Site in New York City since 2018. She has investigator experience supporting multiple HVTN protocols, including HVTN 115, 122, 127, 130, 136, 137, and more recently for HVTN 706 (Mosaico). In addition, she has a role leading community engagement and recruitment efforts for the CRS. Dr. Theodore has also supported Covid-19 studies including CoVPN 3002, CoVPN 5002, and the Phase 2/3 Sanofi Covid-19 vaccine study VAT00002. She is a mentor to medical students, Internal Medicine interns and residents, and Infectious Diseases fellows at Columbia University Irving Medical Center.

Mentor: Magda Sobieszczyk, M.D., M.P.H., Harold C. Neu Professor of Infectious Diseases (in Medicine) at the Columbia University Medical Center
Vaccine Equity: The Rollout That Needs a Booster Shot

By: Mitchell Warren, Opinion Contributor For The Hill

We are over a year into one of the most challenging rollouts of a global health technology product — the COVID-19 vaccines.

With almost half the world fully vaccinated against the pandemic, we can look at the glass as either half full or half empty — it depends on where you are and who you are. The lowest vaccination rates can be found in low-income or low-middle income countries, and among the most marginalized populations within nearly every country. So while COVID-19 vaccine development is a great example of scientific progress, its delivery reflects tragic inequity.

COVID-19 has shown us the fragility of our efforts to end diseases in places where poverty is entrenched. Programs that tackle tuberculosis (TB), for example, were sharply reduced, and the most recent World Health Organization (WHO) report showed an increase in TB deaths in 2020 for the first time in more than a decade. When the COVID-19 pandemic started, TB was the world’s most lethal infection, yet efforts to find and treat TB patients lost more than $500 million in funding. This cannot be a zero-sum game and TB should not be worse than when we left it back in February 2020. But TB remains vanquished only in the wealthier parts of the world. In 2020, the U.S. had over 7,100 cases of TB. But in the Democratic Republic of Congo, a much poorer country with roughly one-quarter of the U.S. population, researchers estimate there were 286,000 infections with almost one-third of these undiagnosed and untreated, providing a continuous source of transmission for this contagion.

Consider the PrEP pill for HIV prevention, a combination of two drugs that prevent HIV infections. It was approved by the U.S. Food and Drug Administration (FDA) in 2012, almost two full years after the first of several clinical trials proved its effectiveness. And it took until 2015 for the United Nations to fully embrace the medicine’s potential and adopt a goal for dissemination by 2020, one that we were failing to meet even before the COVID-19 pandemic.
We need to invest not just in research and development of new technologies, but also in the next “d” — delivery. We invest hundreds of millions in large trials but nothing similar on how to disseminate the results to achieve public health impact. This is not unique to any one disease: We have seen it in the lack of global vaccine equity in the COVID-19 response and we’ve seen it in TB and HIV.

We see it most starkly in income disparities. Ever since science began producing answers for the diseases plaguing humanity, wealthier countries have had faster access to new technologies.

Treatment for drug-resistant TB takes up to two years or more. That would be roughly the equivalent of how long the COVID-19 pandemic has lasted to date. A new treatment for highly drug-resistant TB, one that would shorten treatment time from up to two years to six months, has been approved and is being rolled out in more than 30 countries four years after a clinical trial proved its effectiveness. This can be hailed as a breakneck pace in the severely underresourced field of TB research.

In the U.S., the regimen is now available to treat patients in clinical practice, with results published and presented at major conferences. In Ukraine, the regimen was being used successfully to treat patients in a national research program — but now, with bombs regularly striking the country’s healthcare infrastructure, patients are facing horrors that are only compounded by the risk of treatment disruption in a period of mass displacement.

While the poorest are hit hardest, everyone who breathes is at risk. We are achieving breakthroughs in developing new medicines and vaccines, but we are failing to deliver them with equity and with impact. It is well past time to do better — to reduce the time from discovery to impact and to ensure that the impact is equitably distributed.

Mitchell Warren is executive director of AVAC, a global HIV organization, and also president of the TB Alliance Stakeholder Association.

Editors Note: This article, published April 2022, was reprinted with permission from The Hill, the newspaper for and about Congress, breaking stories from Capitol Hill, K Street and the White House.

https://thehill.com/opinion/healthcare/3258692-vaccine-equity-the-rollout-that-needs-a-booster-shot/
In Case You Missed It

Increased Support Needed for a Coordinated Global HIV and COVID-19 Response

By: Anna Altavas, HVTN Core, Seattle, WA, USA

SEATTLE (Mar. 15, 2022) – Leading infectious disease researchers called for a coordinated response to HIV and COVID-19 globally, building on the successes of key donor programs such as the U.S. bilateral President’s Emergency Plan for AIDS Relief (PEPFAR) program and Global Fund to Fight AIDS, TB and Malaria (GFATM) in new perspective piece published in The Journal of the American Medical Association.

“With intersecting pandemics, we must reevaluate our approach in responding to HIV and COVID-19 through two major components: global immunization and enhanced services to people living with and at risk for exposure to HIV,” said Dr. Larry Corey, professor in the Vaccine and Infectious Disease Division at Fred Hutchinson Cancer Research Center. “Through the key priorities shared in this paper, we can be better equipped to handle what the future has in store for these pandemics on a global scale.”

The emergence of the SARS-CoV-2 omicron variant is a stark illustration of the intersecting COVID-19 and HIV pandemics, highlighting the relationship and detrimental effects each of these infectious diseases has on the other. The authors cite considerable data indicating that immunocompromised persons with persistent COVID-19 could be the origin of SARS-CoV-2 variants of concern (VOC). Sub-Saharan Africa, with its high proportion of persons with HIV infection often undiagnosed and less than optimally treated, has the highest proportion of persons with immunosuppression.

Countries with high HIV infection rates also tend to have low vaccination coverage for COVID-19. The authors advocate for programs to integrate and enhance diagnosis, vaccination and clinical management and research for persons with HIV and COVID-19 and their families and communities.

The piece shares three key priorities to help expand efforts to respond to the pandemics.

- Link HIV diagnosis and care services with COVID-19 vaccination and treatment for all people living with HIV.

- Countries with high HIV incidence must be better resourced to identify people more efficiently with HIV and ensure easy and well-supported access to and monitoring of antiretroviral therapy (ART).

- People living with HIV, especially those with low CD4 counts, must be monitored virologically for persistent COVID-19 infection irrespective of symptoms.

In addition, the global community cannot expect to achieve pandemic control while the continent of Africa is left unprotected from COVID-19 due to inadequate access to vaccines and therapeutics, which omicron has emphasized. Current approaches by both Western and African governments must change, and public health responses must be adequately resourced by donors or other sources and be informed by community voices and perspectives. African governments also need to increase vaccine coverage, possibly through mandates and resources to health services, to reduce the economic and public health burden of these intersecting pandemics on their countries and societies.

Anna Altavas is the Communications Manager for the HIV Vaccine Trials Network and COVID-19 Prevention Network.
Trial of Innovative HIV Vaccine Using mRNA Technology Enrolls First Participant

By: Anna Altavas, HVTN Core, Seattle, WA, USA

SEATTLE (Mar. 14, 2022) – The first 12 study participants have been enrolled in a new Phase 1 clinical trial using the messenger ribonucleic acid (mRNA) vaccine technology developed by Moderna. The study evaluates the safety of and immune responses to three different experimental vaccines against HIV. This randomized, open-label trial represents one of the first clinical studies of the use of mRNA vaccine technology against HIV.

The study, HVTN 302, will enroll up to 108 HIV-negative adults. The primary study hypotheses are that the mRNA vaccines will be safe and well-tolerated among HIV-negative people, and will elicit neutralizing antibodies.

The experimental vaccines carry mRNA, a piece of genetic code, delivering instructions to cells for making proteins, in the same way that the mRNA vaccines against COVID-19 instruct the body’s cells to make the SARS-CoV-2 spike protein. These instructions show human muscle cells how to make small portions of proteins that resemble parts of HIV, but are not the actual virus. People cannot get HIV from the vaccines. Once human immune cells have used the instructions, the mRNA is quickly broken down, and does not stay in the body.

“The data we obtain will help guide design and clinical testing of a future HIV vaccine and hopefully will expand on the knowledge we have already gained using an mRNA vaccine for COVID-19.”

The investigational vaccines are not expected to provide protection from HIV infection, yet the knowledge gained from this study will aid in the future development of an HIV vaccine regimen. Researchers hope to learn whether the immune system will respond to the experimental vaccines by making antibodies and T cells that could fight HIV if a person is ever exposed to the virus in the future. The trial will also build knowledge about how the immune responses to an mRNA vaccine compare to the responses to protein-based vaccines, while helping define the potentials of using mRNA to increase the pace of developing an HIV vaccine.

“With an estimated 1.5 million individuals worldwide acquiring HIV in 2020, it’s crucial that a study like this be done,” said Dr. Larry Corey, Principal Investigator of the HVTN, which is based at Fred Hutchinson Cancer Research Center. “We have been studying various HIV vaccines for decades and the science continues to progress, especially with the major advancements in the COVID-19 vaccines involving the use of the mRNA technology. Applying this technology to HIV vaccine research is a defining moment for the field.”

Participating clinical trial sites are located in Birmingham, AL – University of Alabama-Birmingham; Boston, MA – Beth Israel Deaconess Medical Center and Brigham and Women’s Hospital; New York, NY – Columbia Physicians & Surgeons and New York Blood Center; Philadelphia, PA – University of Pennsylvania; Pittsburgh, PA – University of Pittsburgh; Rochester, NY – University of Rochester; Seattle, WA – Seattle Vaccine Trials Unit; and Los Angeles, CA – UCLA Vine Street Clinic.

The trial is sponsored by the Division of AIDS (DAIDS) of the National Institute of Allergy and Infectious Diseases (NIAID) within the National Institutes of Health (NIH). Study products are provided by IAVI on behalf of the Scripps Consortium for HIV/AIDS Vaccine Development (CHAVID).

Anna Altavas is the Communications Manager for the HIV Vaccine Trials Network and COVID-19 Prevention Network.
Black Contributions to Vaccine Development

This Black History Month, we celebrated by highlighting Black contributions to vaccine development. Learn more about Black public figures including Onesimus, Henrietta Lacks, Dr. Russell Brown and Dr. James Henderson, Dr. Kizmekia Corbett, and Dr. Stephaun Wallace, who all had key roles in charting the course of the development of vaccines that have changed the face of healthcare today.

1700s

HIGHLIGHTS:

• In 1706, an enslaved West African man was purchased for the prominent Puritan minister Cotton Mather by his congregation. He was named Onesimus after an enslaved man in the Bible whose name meant “useful.”

• In 1716, Onesimus told Mather that he knew how to prevent smallpox. The method consisted of rubbing pus from an infected person into an open wound on the arm in a controlled manner and under the supervision of a physician so the symptoms would be milder but still confer immunity. Once the infected material was introduced into the body, the person who underwent the procedure was inoculated against smallpox. It wasn’t a vaccination, which involves exposure to a less dangerous virus to provoke immunity, but it did activate the recipient’s immune response and protected against the disease most of the time.

• The idea of inoculation was unpopular at the time but in 1721, a smallpox epidemic spread from a ship to the population of Boston. Mather and Zabdiel Boylston, the only physician in the city who supported the technique, got their chance to test the power of inoculation. Of the 242 people he inoculated, only six died—one in 40, as opposed to one in seven deaths among the population of Boston who didn’t undergo the procedure.

• In 1796, Edward Jenner invented the smallpox vaccine, a similar but safer inoculation technique using cowpox. Eventually, smallpox vaccination became mandatory in Massachusetts.

• Smallpox remains the only infectious disease humans have successfully eradicated from the Earth.
HIGHLIGHTS:

• Henrietta Lacks died at age 31 of cervical cancer in October 1951. During her treatment, it was discovered that Lacks’s cells (taken without permission) miraculously thrived and doubled every 20 to 24 hours, the hospital said — making them the first living human cells to survive and multiply outside the human body.

• For decades, her cells, known medically as “HeLa cells”, which have been reproduced billions of times for medical research and contributed to approximately 75,000 studies, paving the way for advancements of lifesaving vaccines such as HPV, which protects against cervical cancer, the disease that killed her.

• Henrietta’s cells were also used in developing the polio vaccine, medications for HIV/AIDS, and breakthroughs for in vitro fertilization. The World Health Organization (WHO) also noted that the “cells are currently used in vital research for COVID-19 response efforts.”

• The WHO acknowledged that her legacy was laced with inequity and expressed hope that Lacks’s growing international recognition would go toward “rectifying unjust disparities in global health.”

• In the early 1950s, Poliomyelitis, or Polio, caused the worst damage among children under 5 years old, and Polio was consequently called Infantile Paralysis.

• Medical researcher Jonas Salk created a Polio vaccine that, when injected, stimulated the immune system to make antibodies that fought off the virus. But before moving ahead, Salk wanted to make sure his vaccine was the “safest and most certain” approach by monitoring the inoculation’s ability to trigger enough antibodies to neutralize the virus. Fortunately, researchers had found the HeLa cells, the living line of cancer cells that were taken without permission from a Black patient named Henrietta Lacks years earlier.

• To evaluate his vaccine, Salk would need tremendous amounts of HeLa cells. In October 1952, looking ahead to Polio vaccine testing, the National Foundation for Infantile Paralysis (NFIP) director of research, Harry Weaver, asked Russell W. Brown, director of the Carver Research Foundation at the Tuskegee Institute, to turn its halls into the world’s first HeLa cell factory. Brown, who had a doctorate in bacterial physiology, was designated as the director of the project, and James (Jimmy) Henderson, a plant physiologist, assisted him.

• These Black men were asked to serve humanity in a time when their humanity was often denied. Not far from them, the infamous Tuskegee Syphilis experiment was underway. Both Brown and Henderson were solid scientists, but growing, storing, and maintaining HeLa cells had not been part of their technical training so they traveled to Minnesota to learn the basics of cell and tissue culture and designed their Tuskegee laboratory. By early 1954 the HeLa cell factory was ready to be part of the world’s biggest experiment.

Continued on the next page...
1900s

• On April 26, 1954, the field trial for Salk’s polio vaccine began. This trial was a medical logistics effort on a scale never seen before. Within this huge health campaign was an astronomical number of HeLa cells. These cells, originating from a Black woman and cultivated by Black scientists, made visible the effectiveness of a long-awaited protection against Polio. On April 12, 1955, it was announced that the vaccine was “safe, effective and potent.”

• The inoculation was approved for distribution, cases of the disease began to drop, and Salk went on to become a national hero. But the role of the Tuskegee Institute and its researchers remained hidden long after the fear of Polio faded from the nation’s memory.

2000s

HIGHLIGHTS:

• Stephaun E. Wallace, Ph.D., M.S. is an expert in developing, implementing and evaluating major public health and human service programs in the areas of prevention, care and treatment of HIV/AIDS and other infectious diseases.

• He is the Director of External Relations of both the HIV Vaccine Trials Network and the COVID-19 Prevention Network. These international clinical trials networks, whose operations are based at Fred Hutch, conduct studies of investigational vaccines and other agents intended to protect people from these diseases.

• Dr. Wallace leads the networks’ external relations strategies and efforts globally, with a focus on building long-term relationships with key stakeholders. His strategies create opportunities for consultation with stakeholder communities to inform the design and implementation of the networks’ studies and to optimize the participation of those who bear the greatest burdens of HIV and of COVID-19.

• An internationally recognized leader and speaker in public health and social justice, Dr. Wallace has more than two decades of experience in sexual and public health, social justice, and community mobilization within diverse populations globally. He views public health work through a social justice lens to understand how population-level health is affected by structural and social factors like stigma, racism, sexism, historical trauma and inequalities in education and income.

• Dr. Wallace also serves as the Director of the Office of Community Engagement in the University of Washington/Fred Hutch Center for AIDS Research, a Clinical Assistant Professor, Department of Global Health, University of Washington, and faculty in the Administrative Core at the University of Washington/Fred Hutch Center for AIDS Research.

• Dr. Kizzmekia - Kizzy- Corbett is an expert on the front lines of the global race for a SARS-CoV-2 vaccine, and she will go down in history as one of the National Institutes of Health’s leading scientists in developing the science that could end the pandemic.

• Even before Dr. Corbett took on one of the most challenging tasks of her professional career, she was selected as a student to participate in Project SEED, a program for gifted minority students that allowed her to study chemistry in labs at the University of North Carolina at Chapel Hill. Dr.Corbett spent her summers at laboratories and earned a summer internship at the NIH, the very place where she would be instrumental in developing a vaccine for the coronavirus.
• After graduating, Dr. Corbett enrolled in a doctorate program at UNC-Chapel Hill, where she worked as a research assistant studying virus infections and eventually received a PhD in Microbiology and Immunology. Her work with such pathogens began when she joined the NIH’s Vaccine Research Center as a postdoctoral fellow in 2014.

• The reason she started to work in Coronavirus was not to ever develop a vaccine but to have such a strong understanding of vaccine immune responses to potentially develop one.

• Dr. Corbett was part of a team of scientists who spoke with President Donald Trump at the NIH. In her words: “I felt like it was necessary to be seen and to not be a hidden figure”. “I felt that it was important to do that because of the level of visibility that it would have to younger scientists and also to people of color who have often worked behind the scenes and essentially who have done the dirty work for these large efforts toward a vaccine.”

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The Full Picture: Accurately Framing COVID-19 Vaccine ‘Hesitancy’ among Black Americans

Allysha C. Maragh-Bass, Scientist, Global Health and Population Research, FHI 360
Louis B. Shackelford, External Relations Project Manager, CoVPN

Editors Note: This article was first published in FHI360’s blog April 2021 at: https://degrees.fhi360.org/2021/04/the-full-picture-accurately-framing-covid-19-vaccine-hesitancy-among-black-americans/. It has been reprinted with permission from the authors and FHI360.
As Black American public health professionals, we know that one pervasive question for Black Americans today is, "So, are you getting the COVID vaccine?"

There is not an easy answer. Black Americans are more likely to get COVID-19 than other races and are dying at nearly twice the rate of White Americans. They are also less likely to participate in COVID-19 vaccine clinical trials and are less willing to get the vaccine. All the same, these numbers portray problems in our society, not problems with Black people.

We should look through the lens of lessons learned when Black Americans are left behind in public health preparedness. For instance, many parallels exist between HIV and COVID-19: Black Americans are also more likely to get HIV, less likely to participate in HIV clinical research and less likely to benefit from HIV prevention medications than other communities. While other communities mounted a response to the COVID-19 pandemic, many Black Americans navigated intersectional COVID-19, HIV, racial discrimination and poverty.

What have we learned from both cases?

- Words, images, and perceptions matter. We are inundated daily with headlines about COVID-19 vaccine ‘distrust’ or ‘hesitancy’ among Black Americans. But what is the difference, and does it matter? In short, yes.

Vaccine hesitancy is broadly defined as a continuum from vaccine refusal to acceptance. The headlines using this phrase imply personal preferences and views. However, there is plenty of literature that shows our individual decision-making to get vaccinated may be reduced because of seeing these very images telling us that Black Americans are not getting vaccinated. Very few of these headlines identify trustworthy sources for Black Americans to go for information about the vaccines. Even fewer headlines discuss the role of clinicians and researchers in working to overcome distrust and negative perceptions of the vaccine and in encouraging trust in vaccinations.

- Trust is central to uptake. Whether we portray it as hesitancy, mistrust, distrust or any other term, every Black American needs access to information about the vaccine and side effects. They need to know why some groups are eligible to be vaccinated before other groups and why high rates of vaccination are needed for everyone to be protected (community, or herd, immunity). Black Americans are rightly distrustful of the short timeline to COVID-19 vaccine approval and production. There is not a single community in which we, the authors, have worked, whether on COVID-19 or HIV, where the legacy of ethical violations such as the Tuskegee study or Henrietta Lacks is not mentioned. If public health practitioners are not appropriately equipped to help Black Americans overcome these valid concerns, how can trust be built and vaccine acceptance be promoted successfully? Acknowledging these very real concerns, as the U.S. Surgeon General did, is a start in trust building, but we must continue to provide education about the process through which the vaccine was tested and produced.

- Address the issue of access. Across the media, we see portrayals of vaccine hesitancy in Black American communities, often with little to no effort to balance reporting on vaccine scarcity due to lack of access. Stories abound of Black American communities where low vaccine stock is to blame for low rates of vaccination, not hesitancy. Additionally, structural racism has guaranteed Black Americans a poorer quality of care than others, even when they are willing to seek care. Even before vaccine availability, there were disparities in access to COVID-19 testing.

Public health practitioners must take cues from people already leading these efforts so as not to dilute or duplicate; many of these leaders have worked in HIV prevention and know the pitfalls of repeating the errors of the past. Media outlets should also ensure accurate and balanced reporting that frames the whole community, not just one narrative of hesitancy. Partnering with Black churches and having Black researchers and clinicians in leadership roles in entities like the COVID-19 Prevention Network, the National COVID-19 Resiliency Network and the Black Coalition Against COVID can prioritize engagement in Black American communities and go a long way toward building on assets and promoting vaccinations.

So, are we getting the COVID-19 vaccine? One of us already has and one of us will, to protect ourselves and our community. How about you?

Dr. Maragh-Bass is a former HIV Prevention Trials Network (HPTN) Domestic Scholar and a current FHI 360 Scientist. Mr. Louis B. Shackelford is a Project Manager in External Relations with the COVID-19 Prevention Network (CovPN) and HIV Vaccine Trials Network (HVTN).
Pew Research estimates that 84% of the world’s population identifies with a faith community, and the World Health Organization (WHO) estimates that 40% of health care services in low- and middle-income countries are provided by faith-based institutions. More specifically, faith-based institutions deliver 40% of HIV and AIDS services in sub-Saharan Africa and as much as 60% of HIV related services in other parts of the world. It’s evident that faith is interwoven into the fabric of the human experience, with health and wellness as a core value across all faiths. It’s also true, however, that different faith traditions and belief systems have acted as barriers in the HIV and AIDS response, offering judgement for people living with HIV, and earning the faith community a legacy of perpetuating stigma and discrimination against vulnerable key populations.

At the height of the epidemic in the late 1980s and early 90s, houses of worship were often the final resting place for people who had died from HIV related illness, a place to dignify the dead where they were not always dignified in life. In a 1994 New York Times article titled, “Ritualizing Grief, Love and Politics; AIDS Memorial Services Evolve Into a Distinctive Gay Rite,” Tom Viola of Broadway Cares/Equity Fights AIDS was quoted saying to a priest, “I’m tired of being welcome in the Catholic Church dead. Until they welcome
us alive, it would be ridiculous for them to have the last word at memorial services.” HIV was a death sentence then, and the faith community had gotten good at welcoming people dying with HIV.

However, the advent of highly active antiretroviral therapy (HAART) changed the course of the pandemic such that death no longer had the last word. Neither did faith communities that found purpose in HIV death but struggled to identify its role among people living with HIV thanks to science and medicine – as if God required something more of us than to extend compassion, grace, dignity, and love to our neighbor. Professor Barbara Brown Taylor writes, “When my religion tries to come between me and my neighbor, I will choose my neighbor. Jesus never commanded me to love my religion.”

The good news is that just as the HIV epidemic experienced a biomedical renaissance that shifted the course, more and more people of faith and goodwill have come to share Professor Taylor’s sentiments, understanding that HIV is no longer just about viral load and T-cells. HIV/AIDS is a social justice imperative about poverty, systemic racism, LGBTQIA discrimination, gender inequality, substance use disorders, mass incarceration, political propaganda, and stigma, and these ills can’t be cured in a laboratory or hospital. They can, however, be cured in places of worship, family households, the workplace, and in community. Today, HIV and AIDS are as much a moral mandate as they are a medical one, and no people are better suited to respond to the moral and medical mandate to end HIV than people of faith.

Faith communities around the world are actively building bridges of collaboration with each other, and with government, civil society, academia, and marginalized populations, to combat HIV. And with collaboration comes the perception that faith and religious communities are only a part of the problem and not the solution. Over the years, initiatives like the Interfaith Health Platform (https://www.interfaith-health-platform.org/) have emerged as a multi-religious collaborative space for capacity building, awareness raising, and joint advocacy among faith groups, organizations and communities engaged in HIV and AIDS. It offers access to best practices and resources developed by faith groups, and documents and shares the impact of faith models for a more effective HIV response, including under the challenges posed by the COVID-19 pandemic.

Other global commitments to action by faith communities include the 13 MILLION CAMPAIGN (https://www.unaids.org/en/resources/presscentre/featurestories/2020/10/20201006_fi.htm) that is engaging faith leaders, individuals, and communities to promote access to health services to the 13 million children, women and men living with HIV who are not yet on antiretroviral treatment. Within the United States, Christians and other faith partners have coalesced to form the U.S. HIV Faith Coalition (https://www.ucc.org/what-we-do/justice-local-church-ministries/justice-health-and-wholeness-advocacy-ministries/uccan/uscafaith/) and establish National Faith HIV/AIDS Awareness Day (https://www.hiv.gov/events/awareness-days/faith) that encourage faith communities to work together on HIV and AIDS education, prevention, treatment, care and support, and to reduce and eliminate stigma and discrimination. Most recently, faith communities at the forefront of HIV advocacy have been key in the implementation and execution of community engagement strategies as it relates to COVID-19 and vaccine education in vulnerable populations.

Perhaps the most important role of faith positive communities in the HIV response has been the reconciling of sacred-spaces for healing through storytelling that centers the lived experiences of people most impacted by the epidemic who once-upon-a-time could not share in those spaces and feel safe. Whereas the statistics of science inform, stories have the ability to transform; it’s this transition from the transactional to the transformational that can really serve as a balm in Gilead. Stories increase awareness, awareness builds empathy, and empathy is the tie that binds us together.

If the way out of the COVID-19 pandemic has been to stay apart, the way out of the HIV pandemic is to stay together. The intersectionality of this disease means that we can curb HIV illness by fighting all manner of social ills, if we can just manage to do it together. We have all the science and medicine we need to end the HIV epidemic as a public health crisis. What we need now, more than ever, is to treat people and not just disease — and there are no group of people better poised to lead the charge in humanizing the next iteration of the response than the faithful.
Vaccine Hesitancy or Systemic Racism?

By: Tian Johnson, Stephaun E. Wallace, Maaza Seyoum

Minority communities and developing-country populations may approach health services cautiously – and with good reason, given the medical profession’s history of inhumanity. But, by blaming low COVID-19 vaccination rates on vaccine hesitancy, the profession is effectively using this history to victimize the same communities again.

JOHANNESBURG/SEATTLE/ADDIS ABABA – When the United States began to roll out COVID-19 vaccines earlier this year, uptake in black communities lagged behind their white counterparts. Many assumed this was by choice: the history of medical abuses against them had supposedly left African-Americans mistrustful of the public-health intervention. A similar vaccine hesitancy has also purportedly hampered efforts to vaccinate African populations.

But this narrative amounts to little more than obfuscation.

To be sure, minority communities and developing-country populations may approach health services cautiously – and with good reason. From the gynecological experiments J. Marion Sims performed on enslaved black women in the 1800s to the four-decade-long Tuskegee Syphilis Study, in which infected black men were observed but not treated, there is no shortage of instances of medical abuse against African-Americans.

But, by blaming low COVID-19 vaccination rates on vaccine hesitancy, analysts and health-care providers are effectively using this history to victimize the same communities again. Decision-makers should not be permitted to evade responsibility for their failure to serve marginalized groups adequately by recalling the medical profession’s past inhumanity. Instead, these horrific episodes should highlight the deep-rooted systemic racism that pervades health care today – and spur action to address it.

Make no mistake: racism in health care is not a thing of the past. In the US and elsewhere, ethnic and racial minorities have faced substantially higher risks of becoming infected with the new coronavirus or dying from COVID-19. Non-Hispanic blacks comprise 12% of the US population, but 34% of coronavirus deaths (in cities and states that reported deaths by race and ethnicity).

The same barriers and inequities that made ethnic and racial minority communities more vulnerable are undermining vaccine uptake. Chicago’s vaccine-rollout plan is a case in point. The city wanted to deliver doses through neighborhood pharmacies. But this would exclude the mostly non-white communities that live in “pharmacy deserts.” Those same communities are also less likely to have reliable internet access, making it difficult for them to register for a dose.

Similarly, claims that Africans are simply refusing to get vaccinated ignore the affronts against them by rich countries. In fact, most Africans have not had the luxury of choosing whether they want the vaccine, because rich countries have been hoarding doses.

Moreover, the vaccines Africans do have access to – largely those developed in China, Russia, and India – are often not approved in rich countries, and might be far less effective than, say, the mRNA vaccines produced by Pfizer and Moderna (which North Americans and Europeans have largely claimed). How can rich countries blame Africans for hesitating to accept vaccines they themselves have refused?

To add insult to injury, a handful of rich countries, led by the US, spent months blocking negotiations of an emergency waiver of World Trade Organization intellectual-property rules on COVID-19 treatments and vaccines, which

Continued on the next page...
would enable the rapid scaling up of production, in order to protect corporate interests. During the HIV/AIDS crisis of the 1990s and early 2000s, politics and profits similarly won out over the ethical imperative of ensuring affordable access to treatment, leading to hundreds of thousands of unnecessary deaths in the Global South, especially Africa.

US President Joe Biden’s administration recently reversed its position, and is now backing the waiver. But, again, precious time and countless lives have been lost. If populations whose lives are being relentlessly devalued lack trust in the system, is it their fault, or is it the fault of those who are shaping that system?

Non-white communities want the COVID-19 vaccine. In March, a Morning Consult poll found that racial gaps in vaccine willingness in the US were narrowing. As Georges Benjamin, Executive Director of the American Public Health Association, admitted in April: “We overstated the hesitancy issue,” and “understated the structural access issues.”

The same goes for African populations. Last December, a survey conducted by the Africa Centres for Disease Control and Prevention (Africa CDC), in partnership with the London School of Hygiene & Tropical Medicine, indicated that 79% of Africans would take a COVID-19 vaccine if it were deemed safe and effective.

Ensuring that these groups get the vaccine is a job for their leaders. That means both dismantling barriers to access and working to earn the public’s trust. The Africa CDC is setting an important example, meeting vulnerable communities where they are, listening to and acknowledging their expectations and anxieties, and nurturing greater engagement with the public-health system.

Privileged countries and communities will be tempted to continue to put their own needs first. They might even be tempted to continue to disregard the lives of vulnerable populations. But that temptation points to a pandemic without end.

Tian Johnson, Head of the African Alliance, is Civil Society Observer at the Robert Carr Fund, Co-Chair of the African CDC Vaccine Delivery Alliance’s Community Engagement pillar, founding member of the Vaccine Advocacy Resource Group, and an Aspen New Voices 2021 Fellow.

Stephaun E. Wallace, a staff scientist at Fred Hutch, is Director of External Relations at the HIV Vaccine Trials Network and COVID-19 Prevention Network and a Clinical Assistant Professor of Global Health at the University of Washington.

Maaza Seyoum is African Coordinator of the People’s Vaccine Alliance and Partnerships Lead of the African Alliance.

Editors Note: This article, published June 2021, was reprinted with permission from Project Syndicate, who believes the entire world deserves access to its greatest minds, and makes it their mission to reach those without that opportunity.

UPCOMING MEETINGS/CONFERENCES/AWARENESS DAYS

US NATIONAL HIV TESTING DAY
27 June, https://www.hiv.gov/events/awareness-days

EUROPEAN AIDS TREATMENT GROUP (EATG)’S SCOPE PROJECT F2F MEETINGS
Berlin, Germany 29 June – 1 July 2022, https://www.eatg.org/events/

ADHERENCE 2022

2022 INTERNATIONAL WORKSHOP ON HIV & PEDIATRICS

AIDS2022
Hybrid/Montreal, Canada 29 July – 2 August 2022, https://www.aids2022.org/

US NATIONAL FAITH HIV/AIDS AWARENESS DAY
29 August, https://www.hiv.gov/events/awareness-days

US NATIONAL HIV/AIDS AND AGING AWARENESS DAY
18 September, https://www.hiv.gov/events/awareness-days

US NATIONAL GAY MEN’S HIV/AIDS AWARENESS DAY
27 September, https://www.hiv.gov/events/awareness-days

2022 US CONFERENCE ON HIV/AIDS
San Juan, Puerto Rico 8-11 October 2022, https://uscha.life/

US NATIONAL LATINX HIV/AIDS AWARENESS DAY
27 September, https://www.hiv.gov/events/awareness-days

AMERICAN PUBLIC HEALTH ASSOCIATION ANNUAL MEETING
Boston, MA, USA 6-9 November 2022, and Virtual, 14-16, November, 2022, https://www.apha.org/annualmeeting

WORLD AIDS DAY
27 September, https://www.hiv.gov/events/awareness-days

US NATIONAL BLACK HIV/AIDS AWARENESS DAY
7 February, https://www.hiv.gov/events/awareness-days
New Red Ribbon Registry

By: Sally Bock & Michael Ferguson, HVTN Core, Seattle, WA, USA

In recognition of National HIV Vaccine Awareness Day, May 18, the HVTN is excited to launch its Red Ribbon Registry which enables volunteers across the US to join a community of individuals who are ready help end HIV through the discovery of a preventive HIV vaccine.

On the website, HelpEndHIV.org, volunteers can learn about HIV and progress in vaccine research. Those who are interested in joining a study can complete a survey to join the Red Ribbon Registry, enabling them to sign up to be contacted by a clinical research site about studies in their area for which they could be a good fit.

The fight against HIV has progressed thanks to long-standing collaboration between researchers and community members. With the Red Ribbon Registry and our national advertising campaign, we continue to invite a new generation of community members into the process as important partners in the advancement of science and the ending of suffering and death from HIV-related illnesses.

The Red Ribbon Registry is built upon the same platform provided at no charge to the COVID-19 Prevention Network by Oracle for the rapid recruitment of volunteers for the US COVID-19 vaccine studies. The registry is a cloud-based system that helps accelerate the clinical study enrollment process by making it easy for anyone to volunteer by completing a questionnaire from their desktop computer or mobile device. Researchers can then analyze volunteer data and contact nearby volunteers to tell them about available clinical trials, and potentially enroll them in a study for which they are eligible.

Oracle and HVTN have been working on improvements to the platform over the last year, including features to allow sites to manage users themselves, simplifying the set-up of a geographic catchment area to see the number of available volunteers within that area, and improving accessibility to volunteers’ survey answers to cut down on pre-screening time for site staff and volunteers.

Sally Bock is the Senior Director of Marketing, and Michael Ferguson is the Director of Marketing of the HVTN.
Serafim Armesto lived many stories that can be narrated in a unique way through his large experience working in the HIV field. He was always charismatic, joyful and filled with a generosity of being. He was a presence in our lives. He leaves an important legacy of community involvement in the field of clinical research in HIV prevention and treatment, and recently in the field of HIV preventive vaccines and COVID-19, especially in the Baixada Fluminense metropolitan area of Rio de Janeiro. He played an important role in the PrEP clinical trials in Rio de Janeiro with extensive experience working with gay and transgender women communities in the outskirt areas. He earned his bachelor in Psychology. He was also a counselor, mainly with HIV-positive pregnant women. He was part of the Community Engagement team at the HGNI site in Nova Iguaçu, Rio de Janeiro. Serafim will always be present in the history of HIV prevention and treatment in Brazil!
HVTN WELCOMES

DANIEL D. DRIFFIN, MPH

Daniel Driffin joined the HVTN on April 11, 2022. As External Relations Project Manager, Daniel is one of the newest members of the External Relations Unit based in the HVTN Leadership and Operations Center (Core) at Fred Hutchinson Cancer Research Center in Seattle, WA. Daniel’s primary focus will be implementing stakeholder engagement strategies domestically and globally. These strategies create opportunities for consultation with key stakeholders and communities to inform the design and implementation of Network studies. Consultations will optimize the inclusion and participation of populations and communities who bear the greatest burden of HIV and COVID-19.

Daniel has worked at the intersection of advocacy and assisting communities impacted by HIV for the past decade in Atlanta, GA. Daniel is the creator of and Senior Advisor to D3 Consulting, LLC. The consulting firm assists small-to-midsize community-based organizations, health departments and other programs aligned with engaging men of color within health care settings, not limited to HIV prevention, research, and treatment, but also within systems providing increased health literacy and culturally connected services. He most recently served as co-founder and Director of External Affairs with THRIVE Support Services, Inc., a patient-advocacy and social support network for Black gay men living with HIV.

Daniel received his Bachelor of Science in Biology from Morris College, and a Master’s degree in Public Health from Morehouse School of Medicine. Currently, Daniel is pursuing a doctoral degree in public health from Georgia State University. He hopes to leverage his DrPH training to continue using his influence to create community-driven solutions to improve HIV health outcomes for marginalized communities.

KYLE GORDON

Kyle Gordon joined the HVTN on April 11, 2022. As External Relations Project Manager, Kyle is one of the newest members of the External Relations Unit based in the HVTN Leadership and Operations Center (Core) at Fred Hutchinson Cancer Research Center in Seattle, WA. Kyle’s primary focus will be implementing stakeholder engagement strategies domestically and globally. These strategies create opportunities for consultation with key stakeholders and communities to inform the design and implementation of Network studies. Consultations will optimize the inclusion and participation of populations and communities who bear the greatest burden of HIV and COVID-19.

Kyle is a social entrepreneur and public health strategist, and currently a Master of Health Administration candidate at Tulane University. Working at the intersection of community engagement, public health, social service, and infectious disease, Kyle has dedicated the last 15 years to ensuring that marginalized communities have access to the holistic healthcare they deserve. He began his career in Los Angeles advocating for individuals affected by HIV/AIDS, helping to educate them and connect them with the treatment and social services they needed. He later worked to encourage engagement in advocacy and clinical research at the local, state, national, and global levels serving as an organizing member of California End the Epidemics campaign, as well as serving as the Clinical Research Site liaison to the HIV Prevention Trials Network Global Community Working Group. Kyle has also written peer-reviewed publications for the journal AIDS & Behavior focusing on medication readiness. Kyle holds membership with professional organizations including Alpha Phi Alpha Fraternity, Inc., and the American College of Health Executives. In their free time, Kyle enjoys Broadway plays, working out, traveling, and bowling.
Since 2009, the Legacy Project at the Office of HIV/AIDS Network Coordination (HANC) has worked to address issues that influence the participation of underrepresented populations in HIV clinical research. The Legacy Project team consists of Russell Campbell, Brian Minalga, Pedro Goicochea, and Tasia Baldwin. Here are a few highlights of what the Legacy Project is up to in 2022!

**The Representative Studies Rubric**

The NIH-funded HIV/AIDS clinical trials networks are leading the way to ensure that underrepresented populations are included in their research. Black, Indigenous, and Latinx people. Youth, cisgender women, and transgender people. People who inject drugs and people who undergo pregnancy. Too often, these populations are excluded, neglected, or otherwise underrepresented in HIV research. And too often, researchers explain this underrepresentation by characterizing these populations as “hard-to-reach” and “mistrustful.”

The HANC Legacy Project’s Representative Studies Rubric (RSR) uproots this narrative by revealing, through evidence-based methodologies, systemic and institutionalized practices within clinical research that perpetuate the exclusion of underrepresented populations.

Created by the Legacy Project in 2021, the RSR is a tool consisting of a 12-item questionnaire designed to identify the extent to which individual study protocols include and exclude underrepresented populations. Led by Brian Minalga, a group of Legacy Project Working Group members performed an RSR analysis of 100% of studies that were enrolling in the ACTG, HPTN, HVTN/CoVPN, IMPAACT, and MTN in September 2021. This analysis identified gaps in inclusion practices that the Networks are working to address. Data generated by this analysis have been presented to Network leadership, who in turn nominated representatives from their respective Networks to join the HANC-facilitated RSR Working Group, with the goal of implementing the RSR as a protocol development tool to ensure that questions of inclusion and representation are considered as early as possible and throughout the protocol development process. In 2022, the Legacy Project is dedicated to supporting the Networks and all their study teams in implementing the RSR as a protocol development tool. Legacy Project activities to support RSR implementation include:

- Creating Network-specific reports detailing the performance of each study analyzed in 2021 within each of the RSR’s 12 domains
- Meeting with various teams within each of the Networks to present data from the 2021 RSR analysis and support forward-looking implementation
- Facilitating cross-Network RSR Working Group meetings to strategize and harmonize RSR implementation
- Expanding the reach of the RSR to our partners, collaborators, and colleagues by presenting the RSR at conferences such as the International Workshop on HIV & Women and AIDS 2022.

The NIH-funded HIV/AIDS clinical trials networks exemplify dedication to inclusion and representation in HIV research conducted around the world. The Legacy Project team is proud to support the Networks in achieving their mission to end the HIV epidemic—for all.

**Podcast**

**H=H, the H is for Human, the podcast that centers on the human in HIV**

H=H is produced by the Legacy Project with the purpose of delivering content on HIV research education, affirming Black, Indigenous, and other People of Color (BIPOC) and sexual gender minority communities disproportionately impacted by HIV. H=H was launched on November 1, 2021, and six episodes have been aired:

- **Episode 1: The H is for Human.** This episode introduces the Office of HIV/AIDS Network Coordination (HANC), the Legacy Project and working groups, the Division of AIDS (DAIDS) and the HIV/AIDS research networks.
- **Episode 2: World AIDS Day.** In observance of World AIDS Day, this episode includes interviews with HANC Director, Jeff Schouten, and HIV/AIDS research networks leaders: Judy Currier (ACTG), Wafaa El-Sadr

Continued on the next page...
and Myron Cohen (HPTN), Georgia Tomaras (HVTN), and Sharon Nachman (IMPAACT).

**Episode 3: A conversation with Dr. Carl Dieffenbach.**

In this first episode of 2022 Dr. Jeff Schouten, HANC Director, interviews Dr. Carl Dieffenbach, the Director of the Division of AIDS of the National Institutes of Health.

**Episode 4: The health of transgender people.**

Transgender people are one of the groups most impacted by the HIV epidemic. Episode 4 is devoted to the health of transgender people with interviews with Jessica Xavier and Maria Roman-Taylorson.

**Episode 5: Transgender women's health research.**

This episode is devoted to research being conducted with transgender women in the context of the Division of AIDS (DAIDS) research agenda. Rona Siskind discusses how DAIDS approaches research pertaining to transgender people, and doctors Tonia Poteat and Jordan Lake discuss their studies.

**Episode 6: Latinx & HIV.**

The National Latinx Conference on HIV/HCV/SUD. This episode reports on the 2022 Latinx Conference on HIV/HCV/SUD March, Albuquerque, NM. We interview Pedro Coronado, conference director, Jose Romero on Language Justice, Miguel Chion on training HIV health care providers during the COVID-19 epidemic, and Daniel Roque about the National Hispanic/Latinx Health Policy Agenda 2022-2024 released by the Latino Commission on AIDS.

**The President’s Advisory Council on HIV/AIDS (PACHA)**

PACHA’s Subcommittee on Stigma and Disparities invited the Legacy Project to participate in a meeting that will generate US national recommendations on HIV cluster detection and response (CDR) activities. CDR involves identifying and responding to HIV transmission patterns through a process called molecular HIV surveillance (MHS), in which the genetic relatedness of HIV in many different people is used to monitor different HIV strains.

Brian Minalga is the Legacy Project’s resident expert in CDR/MHS ethics and community engagement, having presented at various conferences and published several journal articles on the topic. The ethics of HIV genetic sequencing and related activities are relevant to the NIH-funded HIV/AIDS clinical trials networks, which perform HIV genetic sequencing in some studies (with the consent of participants, as required in all aspects of clinical research). Brian traveled to Atlanta for this meeting, which took place May 9-10.

**Be the Generation to End the HIV Epidemic**

Having led to the approval of pills, rings, and shots that prevent HIV transmission, biomedical HIV prevention research has never held more promise to end the HIV epidemic. But if we aren’t working to end the HIV epidemic for all, then we’re not really working to end the HIV epidemic. People who are underrepresented in HIV prevention research are also underrepresented among those who benefit from biomedical HIV prevention tools. The Legacy Project’s Be the Generation (BTG) initiative is working to ensure that underrepresented populations have the opportunity to engage in HIV prevention research. Here’s how we’re supporting this generation to be the generation to end the HIV epidemic:

- **BTG website**: the place to go online for information on biomedical HIV prevention research focused on PrEP, U=U, microbicides, and vaccine research
- **BTG newsletter**: the Legacy Project’s quarterly newsletter bringing the latest in biomedical HIV prevention research to the community (sign up by emailing bminalga@fredhutch.org)
- **BTG trainings**: comprehensive training modules that you can download to hold a training in your community on biomedical HIV prevention research—or invite the Legacy Project to do a training for you!
- **Historically Black Colleges and Universities (HBCU) initiative**: Russell Campbell attended and presented the HIV Prevention Research module (HPR Module) as part of the Duke CFAR Diversity, Equity, and Inclusion Pipeline Initiative (CDEIPI) at Vorhees University and South University. The program is entitled, “Evidence2Practice” (E2P), and it focuses on leveraging implementation science to recruit HBCU/MSI students into careers in HIV research. E2P is an intensive on-campus workshop-based initiative, anchored by the HPR Module, with the goal of increasing student interest in careers in HIV science, through providing an experience-based...
• Russell Campbell and Tasia Baldwin are working with and providing expertise to the Black AIDS Institute (BAI) on the Health Resources & Services Administration - HIV/AIDS Bureau’s (HRSA/HAB) $8 million grant for a biomedical justice initiative. This four-year project led by BAI, in partnership with Cardea and the Legacy Project, aims to develop a national training program for students from HBCUs to expand and diversify a strong pipeline of HIV advocates and leaders equipped to end the HIV epidemic.

• Tasia Baldwin will facilitate the newly formed Legacy HBCU/MSI Working Group. The purpose of the group is to provide guidance and input on activities related to engaging HBCU/MSI students and staff focused on increasing scientific literacy of the communities most disproportionately impacted by HIV through the utilization of the HPR Module. WG members will:
  • Serve as subject matter experts
  • Review materials and trainings and provide input and feedback on efforts to engage HBCU/MSI students and staff
  • Conduct presentations on HIV and HIV prevention research efforts to audiences using content from the HPR module
  • Meet as part of ad hoc calls

Legacy Project conducted the workshop, “Community Involvement in HIV Prevention Clinical Research” at the 2022 National Latinx Conference on HIV/HCV/SUD in Albuquerque, New Mexico with over 60 participants.

The Legacy Project team recently returned from Chicago, IL, where they reached over 300 conference participants with workshops at the Biomedical HIV Prevention Summit:
  • No Data No More: Manifesto to Align HIV Prevention Research with Transgender and Gender-Diverse Realities
  • Role of Pharmacists along the HIV Prevention and Treatment Continuum
  • Long-Acting Antiretroviral Injectables and Broadly Neutralizing Antibodies - What’s New?
  • Addressing “Addictophobia” to Engage MSM Who Use Drugs in PrEP

Russell, Brian, Pedro, and Tasia hope to see you soon! Here are some dates and places where you can catch up with them:

**June 3-7:** HPTN Annual Meeting in Washington, DC and online

**June 13-17:** ACTG Annual Meeting in Washington, DC and online

**June 28 – July 1:** IMPAACT Annual Meeting in Washington, DC and online

**July 29 – August 2:** AIDS 2022 in Montreal, Canada

**October 8-11:** The US Conference on HIV/AIDS in San Juan, Puerto Rico

Always,
Russell Campbell,
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Tasia Baldwin,
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Seen Around the HVTN

(l to r) DeShay Brown (community member), Miasha Forbes-Alpha Omega (HVTN advocate), Dr. Stephautn Wallace-Marc Jacobs Director of External Relations with HVTN, and Jennifer Barnes-Balenciaga (HVTN advocate) at the Keeping Ballroom Community Alive Network’s COVID-19 Conversation community event in New York, NY, April 2022

NAESM staff (HVTN community partner) at a community health fair in Atlanta, GA, April 2022

(l to r) Emory Hope and Ponce CRS staff: Lydia Stephens, D’Jamel Young, Aryn Prince, and Humberto Orozco doing outreach at a community health fair in Atlanta, GA, April 2022
Rameses Frederick (Emory Hope Clinic) doing outreach at a transgender pageant in Atlanta, GA, April 2022

R&B recording artist Tre Ward performs at the Black & Queer AF music festival cosponsored by the COVID-19 Prevention Network in Houston, TX, April 2022

COVID-19 Prevention Network logo displayed at Black & Queer AF music festival in Houston, TX, April 2022
Dr. Stephaun Wallace, HVTN Director of External Relations, and Jarissa Greenard, Community Educator with Vanderbilt CRS, at the HVTN Full Group Meeting in Washington, DC, May 2022

Dr. Stephaun Wallace HVTN Director of External Relations, opening the second plenary on the importance of HIV vaccines at the HVTN Full Group Meeting in Washington, DC, May 2022

Dr. Carl Dieffenbach, Director of the Division of AIDS (NIAID/NIH), presents the HVTN with an award in recognition of service in the COVID-19 response at the HVTN Full Group Meeting in Washington, DC, May 2022
(l to r) Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIH) and Chief Medical Advisor of the President of the United States, and Dr. Larry Corey (r), HVTN Principal Investigator, during a fireside chat at the HVTN Full Group Meeting in Washington, DC, May 2022

Professor Glenda Gray, HVTN Co-Principal Investigator, presents during the first plenary on the importance of HIV vaccines in sub-Saharan Africa at the HVTN Full Group Meeting in Washington, DC, May 2022

Rosario Leon, Head of Community Engagement for the IMPACTA CTU, presenting during the second plenary on the importance of HIV vaccines in Latin America at the HVTN Full Group Meeting in Washington, DC, May 2022
Nandi Luthuli-Sikwana, Regional Stakeholder Engagement Manager for AVAC, presenting during the second plenary on the importance of HIV vaccines in sub-Saharan Africa at the HVTN Full Group Meeting in Washington, DC, May 2022.

Sally Bock, HVTN Senior Director of Marketing, presenting during the second plenary on HIV vaccine marketing research at the HVTN Full Group Meeting in Washington, DC, May 2022.

James Krellenstein, Co-Founder & Managing Director, Strategy & Policy for PrEP4All, presenting during the second plenary on vaccine equity and pandemic preparedness at the HVTN Full Group Meeting in Washington, DC, May 2022.
Daniel Driffin, HVTN External Relations Project Manager, and Mardrequis Harris, Director of Community Investments with Southern AIDS Coalition (HVTN community partner), pose for a picture during the reception at the HVTN Full Group Meeting in Washington, DC, May 2022

HVTN Social and Behavioral Sciences and Community Engagement team (l to r): Jasmin Aina, Linda Oseso, Giulio Corbelli, Patricia Segura, Rafael Gonzalez, Gail Broder, Luciana Kamel, Dr. Michele Andrasik, Cody Shipman, and Nina Feldman, HVTN Full Group Meeting in Washington, DC, May 2022

Ruth St. Fort, MS (RAMP Cohort 11) from Wright State University Boonshoft School of Medicine, presenting her poster titled “Mobile health (mHealth) interventions for improving HIV prevention knowledge and clinical research literacy among youth communities in Zimbabwe” at the HVTN FGM in Washington, DC, May 2022
India Perez-Urbano (RAMP Cohort 11) from University of California, San Francisco School of Medicine, presenting her poster titled “Patterns of daily pre-exposure HIV prophylaxis use, and barriers and facilitators to access and use in men who have sex with men and transgender persons in Soshanguve, South Africa” to a community member at the HVTN FGM in Washington, DC, May 2022.

Eshiemomoh Osilama, MBS (RAMP Cohort 11) from Geisinger Commonwealth School of Medicine with Mentor, Dr. Jason Zucker, Columbia CRS, at the RAMP Poster Session at the HVTN FGM in Washington, DC, May 2022.

Aliah Fonteh (Cohort 10) from Meharry Medical School, presenting her poster titled “Assessing HIV risk and factors related to HIV seroconversion among low-risk participants in North America and sub-Saharan Africa in the HVTN 100, 107, 108, 111 and 120 studies” to Dr. Alison Roxby, Director of Scientific Mentoring for the HVTN, at the HVTN FGM in Washington, DC, May 2022.
Eshiemomoh Osilama, MBS from Geisinger Commonwealth School of Medicine, presenting his poster titled “Get2PrEP3.0: An initiative to Reduce Missed Opportunities for the Provision of HIV Prevention Services for Patients Testing Positive for STIs” to Dr. Christine B. Turley, Atrium Health, at the HVTN FGM in Washington, DC, May 2022

Aliah Fonteh (RAMP Cohort 10) from Meharry Medical School, presenting her poster titled “Assessing HIV risk and factors related to HIV seroconversion among low-risk participants in North America and sub-Saharan Africa in the HVTN 100, 107, 108, 111 and 120 studies to Dr. Jason Zucker, Columbia CRS, at the HVTN FGM in Washington, DC, May 2022
RAMP Scholars, Mentors, Leadership and Staff. (l to r): Linda Oseso, Dr. Jason Zucker, Dr. Magdalena Sobieszczyk, Lily Bonadonna (Cohort 11), Nicole Na, Dr. Nigel Garrett, Tsion Andine (Cohort 10), Liz Briesemeister, Ruth St. Fort (Cohort 11), Jimena Castellanos Aguirre (Cohort 12), Eshiemomoh Osilama (Cohort 11), India Perez-Urbano (Cohort 11), Aliah Fonteh (Cohort 10), Norman Archer (Cohort 11), Dr. Zoe Moodie, Dr. Allison Roxby, Dr. Janine Maenza, Dr. Jim Kublin and Dr. Michele Andrasik at the HVTN FGM in Washington, DC, May 2022

Cohort 11 RAMP Scholars with their mentors. (l to r): Dr. Jason Zucker, Columbia CRS; Norman Archer, University of California, San Francisco; Lily Bonadonna, Wayne State University; Eshiemomoh Osilama, MBS, Geisinger Commonwealth School of Medicine; Dr. Magdalena Sobieszczyk, Columbia CRS at the HVTN FGM in Washington, DC, May 2022

Tsion Andine (RAMP Cohort 10) from Howard University College of Medicine, presenting on her project titled “Transforming STI care in South Africa: Impact of point-of-care STI testing for Gonorrhoea, Chlamydia, and Trichomoniasis in HVTN trials” at the HVTN FGM in Washington, DC, May 2022
Eshiemomoh Osilama, MBS (RAMP Cohort 11) from Geisinger Commonwealth School of Medicine, presenting on his project titled “Get2PrEP3.0: An initiative to Reduce Missed Opportunities for the Provision of HIV Prevention Services for Patients Testing Positive for STIs” during the RAMP Scholar Presentations Plenary at the HVTN FGM in Washington, DC, May 2022.

India Perez-Urbano (RAMP Cohort 11) from University of California, San Francisco School of Medicine, presenting on her project titled “Patterns of daily pre-exposure HIV prophylaxis use, and barriers and facilitators to access and use in men who have sex with men and transgender persons in Soshanguve, South Africa” during the RAMP Scholar Presentations Plenary at the HVTN FGM in Washington, DC, May 2022.

Norman Archer (RAMP Cohort 11) from University of California, San Francisco School of Medicine, presenting on his project titled “Sexual Behavior and Engagement with PrEP Services during the COVID-19 Pandemic in NYC: A Mixed Methods Study” during the RAMP Scholar Presentations Plenary at the HVTN FGM in Washington, DC, May 2022.
RAMP Scholars, Mentors, Leadership and Staff. (l to r): Linda Oseso, Dr. Jason Zucker, Dr. Magdalena Sobieszczyk, Lily Bonadonna (Cohort 11), Nicole Na, Dr. Nigel Garrett, Tsion Andine (Cohort 10), Liz Briesemeister, Ruth St. Fort (Cohort 11), Jimena Castellanos Aguirre (Cohort 12), Eshiemomoh Osilama (Cohort 11), India Perez-Urbano (Cohort 11), Aliah Fonteh (Cohort 10), Norman Archer (Cohort 11), Dr. Zoe Moodie, Dr. Allison Roxby, Dr. Janine Maenza, Dr. Jim Kublin and Dr. Michele Andrasik at the HVTN FGM in Washington, DC, May 2022

Cohort 11 RAMP Scholars with their mentors. (l to r): Dr. Jason Zucker, Columbia CRS; Norman Archer, University of California, San Francisco; Lily Bonadonna, Wayne State University; Eshiemomoh Osilama, MBS, Geisinger Commonwealth School of Medicine; Dr. Magdalena Sobieszczyk, Columbia CRS at the HVTN FGM in Washington, DC, May 2022
COVID-19 was not the first pandemic of our lifetime.

That’s why we need you to join an HIV prevention study.

We’re looking for people who are not living with HIV, 18-55 years old, and in general good health.

Learn more and register to participate in an HIV prevention study to help end HIV sooner. Go to HelpEndHIV.org*
What is “opt-out” testing for HIV?

“Opt-out” testing for HIV means that HIV tests may be done routinely unless a patient refuses to have the testing done. For more information on the Center for Disease Control’s (CDC) recommendations for HIV testing in the U.S., please visit: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

For (U.S.) state-specific information, please visit: http://www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws/

For other information about HIV testing guidelines in your country, please visit: http://www.who.int/hiv/pub/national_guidelines/en/

Where can I get the right test for HIV?

You can get the right HIV test at the study site for free. After you leave the study you can continue to go to your study site to request HIV testing. If you are no longer located near your study site, the HVTN VISP Testing Service can help you get HIV testing in your area. The testing is free.

FREQUENTLY ASKED QUESTIONS ABOUT VISP

How can I explain this situation to my healthcare provider?

No one can force you to have an HIV test for any reason.

• If anyone asks to test you for HIV or to draw your blood, tell them you are in (or have been in) an HIV vaccine study and that you need to get all your HIV tests at the study site.

• Explain that being tested outside of your study site or the HVTN VISP Testing Service could result in an incorrect diagnosis of HIV infection.

• Give the provider your study coordinator’s contact information. Ask the provider to call the study site or the HVTN VISP Testing Service directly (U.S. toll free: 1-800-327-2932).

• If you have to, simply say “no” to the HIV test, and then ask the study site or the HIV Vaccine Trials Network to help. We are happy to work with you to resolve your situation.

How long does VISP last?

If you have tested VISP, the antibodies may fade quickly or they may last for several years. In some cases, participants continue to test VISP for more than 20 years.

Why don’t standard HIV tests look for actual HIV?

Standard HIV tests that look for antibodies are quick, reliable and affordable. Tests that look for the virus are expensive and not commonly used for an initial diagnosis.

Getting the Right Test for HIV

Antibodies help to prevent infection. Most vaccines cause the body to make antibodies. If you get an HIV vaccine, your body may make antibodies to HIV. However, standard HIV tests search for HIV antibodies, a sign of HIV infection for people who have not previously received an HIV vaccine. If you get a standard HIV test after receiving an HIV vaccine, your HIV test results could come back positive even if you are not infected with HIV. This is called a VISP (Vaccine-Induced Seropositive) test result. To avoid this confusion, our study sites use different kinds of HIV tests that look for the virus itself, not antibodies.
Can VISP be passed from one person to another?

- In most cases, no. If you have tested VISP you cannot pass the antibodies to another person by kissing or through sexual contact.

- If you are pregnant, we think there may be a chance that you could pass the vaccine antibodies to your baby. Although this has not been shown to happen with HIV study vaccines, we know that this happens with other vaccines, like the tetanus vaccine. Vaccine antibodies that mothers pass to their babies are temporary and go away over time, and they are not harmful to the baby. The HVTN can arrange for you and your baby to have accurate HIV testing for free for as long as it is needed.

In order to donate blood or organs, the donation site will screen you using an HIV antibody test. If you test positive for HIV antibodies you may be unable to donate an organ. You may also be permanently banned from blood donation even though you are not infected with HIV.

How will a VISP test result affect me?

- If someone believes you are infected with HIV, you could face discrimination and/or other problems. For example, you could have problems with medical or dental care, employment, insurance, a visa for traveling, or entry into the military. You might not be allowed to donate blood or other organs. If you are pregnant, you may have to explain your situation to avoid receiving any HIV treatment during your pregnancy or labor/delivery.

- If you are planning to apply for insurance, employment, or the military, please inform your study site right away. The insurance company, employer, or military agency may not accept HIV test results from the HVTN. However, the HVTN can work with them to ensure the right test is done that will show your true HIV status.

What happens if I move far away from the study site where I participated in an HIV vaccine study?

For U.S. participants, call the HVTN VISP Testing Service at 1-800-327-2932 during business hours, Pacific Time. For participants outside the U.S., call your study site and they can assist you with testing for HIV. If you are unable to reach someone at your study site, send an email to vtn.core.vispcounselor@hvtn.org to request testing.

The HVTN VISP Testing Service provides HIV testing for participants who have received a study HIV vaccine in a National Institutes of Allergy and Infectious Diseases (NIAID) Division of AIDS (DAIDS)-funded HIV preventive vaccine trial and who are no longer able to be tested at their study site.

Will my information be confidential?

Yes. All of your information will be stored in a limited-access, password-protected, secure computer database. Access to your information will be limited to the HVTN VISP counselors. No identifying information concerning the testing will be released to any third party without your written approval, except when required by law.

How long does the HVTN VISP Testing Service take to provide test results?

Approximately 2 weeks.

Am I eligible for the HVTN VISP Testing Service?

YES:

- If you participated in an HIV Vaccine Trials Network (HVTN), AIDS Vaccine Evaluation Group (AVEG), or HIV Network for Prevention Trials (HIVNET) HIV preventive vaccine study, AND
- If you received an HIV vaccine*, AND
- You are willing to provide consent to have your blood drawn and for HIV testing.

NO:

- If you have a confirmed HIV infection, OR
- If you are currently enrolled in an HIV Vaccine Trial,** OR
- As a former study participant, you received a placebo.

* If you are not sure if you received an HIV vaccine, call the HVTN VISP Testing Service (1-800-327-2932).

** If you are currently enrolled in an HIV vaccine trial, your testing is provided by your trial site. If for some reason you are unable to be tested at your site, you can contact your study site or the HVTN VISP Testing Service (US toll free: 1-800-327-2932).

What if I live outside the U.S.? Will I have access to the HVTN VISP Testing Service?

The HVTN VISP Testing Service is open in the United States. Expansion of the testing service in southern Africa is underway. For locations outside of the U.S., please contact your study site or email vtn.core.vispcounselor@hvtn.org to request testing.

For more information about getting the right test for HIV

Contact your study coordinator at the HIV vaccine study site or the HVTN VISP Testing Service at (US toll free) 1-800-327-2932.
The Mosaico Study, also known as HVTN 706/HPX3002, is a multi-country HIV vaccine study testing whether an investigational HIV vaccine regimen can prevent HIV acquisition in cisgender men and transgender persons who have sex with cisgender men and/or transgender persons. The study is being conducted in Argentina, Brazil, Italy, Mexico, Peru, Poland, Puerto Rico, Spain, and the United States. As of September 10, 2021, the study reached full enrollment of 3,800 participants. The communities and research teams involved in this study are hard at work to find an answer to the scientific questions about safety, immune response, comfortability with injections, and efficacy of the vaccine regimen. Answers to these questions are expected in 2024. The Data Safety Monitoring Board (DSMB) met on May 23, 2022 and recommended the study continue and that it was safe to proceed.

More information about the Mosaico study can be found at [www.mosaicostudy.com](http://www.mosaicostudy.com).

*Dr. Stephaun Wallace is the Director of External Relations for the HVTN and directs community engagement for the Mosaico Study globally.*
A JOURNEY TOWARDS A GLOBAL HIV VACCINE

www.mosaicostudy.com
The HIV Vaccine Trials Network is an international multi-disciplinary collaboration. Support for the HVTN comes from the National Institute of Allergy and Infectious Diseases (NIAID) of the U.S. National Institutes of Health, an agency of the U.S. Department of Health and Human Services. The Network and NIAID have a close, cooperative working relationship, with shared attention to intellectual and scientific issues.

ABOUT COMMUNITY COMPASS
The Community Compass aims to keep the HVTN community informed about the Network’s research, site activities, and advances in the field of HIV prevention and vaccination. We encourage community members to submit news and event reports to this magazine and make this a true community sharing platform.

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VIEW PAST ISSUES OF COMMUNITY COMPASS AT
hvtn.org/en/community/community-compass.html

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