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California Stories

California ranked highest in U.S. for STDs, Kern County ranked number one in Chlamydia

Jessica Harrington, ABC | 12.3

California is ranked highest in the U.S. for reported sexually transmitted disease cases. Kern County ranks highest in reported Chlamydia cases and among the highest in syphilis and gonorrhea.

“I think it’s very surprising considering California is such a large state and I mean there’s multiple cities out there that are bigger in population,” said Nick Rogowski, a local resident.

However, local health officials said the rising number of STDs isn’t the only thing residents should pay attention to.

Local health officials said recently they have been battling a spike in congenital syphilis, which is when a mother with untreated syphilis gives birth and passes it to the baby.

“In newborns it can be a disaster, it basically can destroy your baby,” said Dr. Royce H. Johnson, Chief of Infectious Disease at KMC.

Within the past year 19 cases of congenital syphilis were reported in Kern County, of those, five babies died.

“We’re having innocent new born babies that haven’t even had a chance to get their life started and they’re being impacted by this disease that could’ve been prevented,” said Denise Smith, the Director of Disease Control for Kern County Public Health.

Officials said the disease is highly treatable, but if expecting mothers don’t seek prenatal care, the disease can go undetected.

Officials say over the years Kern County has had a relatively small amount of female syphilis cases, but recently it has spiked.

As the number of women with syphilis rises, so does the number of cases of congenital syphilis.

“You know every single one of our birthing hospitals are being impacted by these moms coming in with no prenatal care and they’re ending up positive for syphilis,” said Smith.

Health officials suggest anyone who is sexually active should use condoms and should be tested regularly.

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amfAR establishes San Francisco-based Institute for HIV Cure Research

As reported by Medical News Today | 12.1

amfAR, The Foundation for AIDS Research, today announced the establishment of the amfAR Institute for HIV Cure Research, an innovative collaborative enterprise based at UC San Francisco (UCSF). As the cornerstone of amfAR's \$100 million cure research investment strategy, the aim of the Institute will be to develop the scientific basis of a cure for HIV by the end of 2020.

The Institute will support teams of scientists working across the research continuum - from basic science to clinical studies - and will tap into UCSF's extensive research network across the region. It will involve collaborations with the Gladstone Institute of Virology and Immunology (GIVI) and Blood Systems

Research Institute, as well as Oregon Health and Science University; University of California, Berkeley; Gilead Sciences; and the Infectious Disease Research Institute in Seattle, Washington.

"We intend to quicken the pace of cure research by supporting a collaborative community of leading HIV researchers in one cohesive enterprise," said amfAR Chief Executive Officer Kevin Robert Frost. "The institute will allow them to conduct the science, share ideas, and test and evaluate new technologies and potential therapies in a state-of-the-art environment. And I can think of no better base for such an enterprise than the San Francisco Bay Area, the crucible of technological innovation in America."

"Furthermore, establishing an institute dedicated to finding a cure for HIV in a city that was once considered ground zero of the AIDS epidemic brings full circle the outstanding work that UCSF's researchers have been doing over the past 30 years," added Frost.

Worldwide, it is estimated that nearly 37 million people are infected with HIV. Current antiretroviral therapy (ART) can help people with HIV live longer and healthier lives, but it cannot eliminate the virus. There is general consensus among the scientific community that the principal barrier to a cure is the reservoirs, or pockets, of virus that remain in a person even after they have reached "undetectable" levels of HIV as a result of ART.

The new Institute, headquartered in UCSF's Global Health and Clinical Sciences Building at Mission Bay, was established with a \$20 million grant over five years. It will enable teams of researchers to work collaboratively, across institutions and across disciplines, to address the four key challenges that must be overcome to effect a cure: pinpoint the precise locations of the latent reservoirs of virus; determine how they are formed and persist; quantify the amount of virus in them; and finally, eradicate the reservoirs from the body.

"For those of us who watched helplessly as thousands died, the opportunity to try to develop an HIV cure is truly amazing," said Paul Volberding, M.D., a UCSF Professor of Medicine who will direct the new amfAR Institute. "We are proud to have been chosen by amfAR as the only amfAR HIV Cure Institute in the nation. We're ready to end this epidemic."

"The San Francisco area has a higher concentration of scientific thought leaders in HIV than anywhere else in the world," said amfAR Vice President and Director of Research Dr. Rowena Johnston. "The Bay Area has consistently led the way in developing and implementing scientific advances in HIV prevention and treatment, and the potential for this team of researchers to develop a cure is unparalleled."

Joining Dr. Volberding on the leadership team will be Mike McCune, M.D., Ph.D., Chief and Professor, Division of Experimental Medicine, UCSF; Warner Greene, M.D., Ph.D., Director and Nick and Sue Hellmann Distinguished Professor of Translational Medicine, Gladstone Institute of Virology and Immunology, Professor of Medicine, Microbiology and Immunology, UCSF, and Co-Director, UCSF-Gladstone Center for AIDS Research; Satish Pillai, Ph.D., Associate Professor of Laboratory Medicine, UCSF, and Associate Investigator, Blood Systems Research Institute; Steven Deeks, M.D., Professor of Medicine, UCSF; Teri Liegler, Ph.D., Director of the Virology Core Laboratory at UCSF-GIVI Center for AIDS Research; and Peter Hunt, M.D., Associate Professor of Medicine in the HIV/AIDS division and a member of the Executive Committee of the AIDS Research Institute at UCSF. They will work in collaboration with Afam Okoye, Ph.D., staff scientist at Oregon Health & Science University.

"This exciting new initiative will bring together the scientific, technological and team-building expertise of amfAR and its Institute partners," said Dr. Johnston. "We are confident that this new combination approach will enable us to rapidly advance the science around a cure for HIV."

View the story online: [Click here](#)

National Stories

Taking Truvada "as needed" can prevent HIV-transmission amongst people at high-risk

As reported by Medical News Today | 12.1

In a study into the prevention of HIV transmission, people who took the antiretroviral drug Truvada were 86% less likely to contract the disease than those who took a placebo, report the researchers who led the study. "The medication was taken as needed around periods of sexual activity. All study participants received regular HIV and STD prevention counselling and services, and stocks of condoms and lubricant," explained Dr. Cécile Tremblay of the University of Montreal and the CHUM Research Centre, who led the Canadian component of the research. "Indeed, this research looked specifically at men and transgender women at high-risk of HIV transmission, which we defined as persons having had unprotected anal sex with two or more different partners within a six month period. This study clarifies the role Truvada can play in protecting this population." The research, which will be published in the New England Journal of Medicine, was led by Dr. Jean-Michel Molina of Hôpital Saint-Louis in Paris and Dr. Jean-François Delfraissy of France's ANRS Research Agency.

In real numbers, fourteen of the 201 people in the placebo group acquired HIV, compared to two in the 199-strong Truvada group. The study was double blinded, meaning that neither the participants nor the researchers knew who was receiving what while the study was being undertaken. Double-blinding enables researchers to demonstrate a higher standard of proof. In addition to the provision of the services mentioned above, participants were provided with enough pills that one could be taken every day during the length of the study, if necessary (a median of 9.3 months.) They were instructed to take two pills before sex, a third pill 24 hours later, and a fourth pill 24 hours after that. When sexual intercourse happened more often, participants were told to take one pill per day and then the two post-exposure pills. "Interestingly, participating in the study did not influence the participants' sexual behaviour," Dr Tremblay said.

The researchers point out that the efficacy of the long term efficacy of strategy evaluated in their study needs to be further studied as it was relatively short and people's adherence to medication regimes tend to drop off over time. However, this was one of the reasons why the study was undertaken: previous studies had shown some efficacy of Truvada as a preventative medicine when taken every day, however adherence was a great challenge, therefore this "as needed" strategy was designed to increase the likelihood that the patient would gain maximum benefit from it. "In both groups, participants took a median of 15 pills per month, demonstrating that they felt able to judge when the medication needed to be taken," Dr. Tremblay said. "However, 28% of the participants did not take the pills at all and a further 29% took them at a suboptimal dose. Indeed, the two people in the medication group who became

infected had not medicated themselves. Ensuring support for long-term adherence to the medication regime will be one of the challenges of working towards successful prevention amongst at-risk people."

Low adherence is in fact one of the reasons why researchers believe that two recent trials involving heterosexual women failed to show any benefit of the drug. Meanwhile, although the placebo arm of the study came to an end after the benefits of Truvada became clear, the scientists continue to work with the study participants, with a view to better understanding how adherence may or may not change over time.

Journal Reference:

[On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection](#), Molina et al.; *New England Journal of Medicine*, doi: 10.1056/NEJMoa1506273, published 1 December 2015

View the story online: [Click here](#)

HIV Prophylaxis Could Benefit 1.2 Million: CDC

But medical providers are unaware of pre-exposure protection

Michael Smith, MedPage Today | 11.25

About 1.2 million people in the U.S. are at "substantial risk" of HIV and could benefit from taking a daily pill to prevent the infection, the CDC said.

Analysis suggests that about 25% of men who have sex with men and 20% of those who use nonprescription injection drugs would benefit from so-called pre-exposure prophylaxis (PrEP), the agency said in a Vital Signs report published online in *Morbidity and Mortality Weekly Report*.

Many of those people are not being offered the measure, in many cases because their medical provider simply isn't aware of the option, according to Anne Schuchat, MD, the agency's principal deputy director.

A recent survey suggested that 34% of primary care providers are not aware of PrEP as a way to prevent HIV, she told reporters in a telephone briefing, even though the FDA approved it in 2012 and the CDC issued formal guidance on how to use it last year.

"Doctors need more prep about PrEP," Schuchat said.

And even in affected communities, awareness can be low, MedPage Today has reported.

On the other hand, a concerted effort to raise awareness of the option in New York state -- involving medical associations, advocacy groups, state and local health departments, and healthcare providers -- was associated with a sharp increase in the number of Medicaid enrollees who took advantage of PrEP, according to a companion study in *MMWR*.

"This type of effort needs to be replicated nationally," commented Eugene McCray, MD, director of the agency's division of HIV/AIDS prevention.

The analysis is "fascinating" because it begins to pin down the extent of the need for PrEP, commented Mitchell Warren, executive director of AVAC, a New York-based nonprofit group that advocates for improved HIV prevention.

"What we know from this new analysis is that well over a million people are likely at what is considered substantial risk for infection," he told MedPage Today. But how many are being offered PrEP and how many are taking it are questions that remain up in the air, he added.

And unlike HIV treatment, which lasts a lifetime, the need for PrEP might vary from time to time. "People will go in and out of being at substantial risk," he said, "so it's not as easy to quantify as one would quantify treatment."

The report from New York state, he said, is "actually even more exciting ... with scaling up the promotion of PrEP and the training of health providers more people will take PrEP."

The idea of PrEP is that HIV-negative people with a small amount of anti-HIV drug in their systems would be protected against the virus if they were exposed. The medication approved for PrEP is the single-pill combination of 300 mg of tenofovir co-formulated with 200 mg of emtricitabine (Truvada).

Clinical trials have demonstrated that the approach is safe and effective in men who have sex with men, injection drug users, and people whose regular sexual partner has the infection.

But "PrEP is never just a pill," Warren said. It is always meant to include other prevention methods, including using condoms and clean needles.

It is a "highly effective" prevention strategy, Schuchat said, adding "we need to make sure clinicians are aware of PrEP."

The main analysis, she said, combined data from several sources to estimate how many HIV-negative people are at substantial risk of the infection, including the National Health and Nutrition Examination Survey, the National Survey on Drug Use and Health, and the National Survey of Family Growth.

The bottom line, Schuchat said, is that an estimated 24.7% of men who have sex with men, some 492,000 people ages 18 through 59, have indications for PrEP. In addition, 18.5% of people 18 and older (115,000 people) who inject drugs could benefit from PrEP. And 0.4% of heterosexually active adults 18 through 59 years have indications for PrEP, or about 624,000 people, including 468,000 women.

Taken together those estimates add up to some 1.232 million adults, although the confidence intervals are wide, from 661,000 to 1.803 million.

The New York report notes that some 3,000 new cases of HIV occur each year in the state, and part of the response has been an increased emphasis on PrEP as a prevention method, including "statewide efforts to increase knowledge of PrEP among potential prescribers and candidates for PrEP."

To estimate the effect of the campaign, investigators turned to Medicaid data from July 2012 through June 2015, using medication and diagnosis codes to look for tenofovir/emtricitabine use for more than 30 days, excluding its use for post-exposure prophylaxis, HIV treatment, or therapy for chronic hepatitis B.

They found that from July 2012 through June 2013, 259 people had PrEP prescriptions through the Medicaid program. The following year -- July 2013 through June 2014 -- 303 got PrEP through Medicaid.

But from July 2014 through June 2015, 1,330 people filled prescriptions for PrEP.

Most were from New York City, male, younger than 50 years, and white, among those with available data on race, the study found.

Primary Source

Morbidity and Mortality Weekly Report

[Source Reference: Laufer FN, et al "Vital signs: estimated percentages and numbers of adults with indications for preexposure prophylaxis to prevent HIV acquisition -- United States, 2015" *MMWR* 2015; 64: 1-6.](#)

Secondary Source

Morbidity and Mortality Weekly Report

[Source Reference: Smith DK, et al "Vital signs: increased medicaid prescriptions for preexposure prophylaxis against HIV infection -- New York, 2012-2015" *MMWR* 2015; 64: 1-6.](#)

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12 months of liquid formula HIV drugs protect breastfeeding babies against HIV infection

As reported by News Medical | 11.20

A study from four countries in Africa, published in *The Lancet*, shows that providing babies with up to 12 months of liquid formula HIV drugs, while breastfeeding with their HIV-positive mothers, is highly effective at protecting them from infection, including in the 6–12 month period after birth which has not been analysed in previous research. The study is by Professor Philippe Van de Perre, INSERM, Montpellier, France, and colleagues.

Strategies to prevent postnatal mother-to-child transmission of HIV-1 in Africa, including directly protecting infants through prophylaxis with special child formulations of HIV drugs, have never been assessed past 6 months of breastfeeding, despite breastfeeding being recommended up to 12 months after birth. In this new study, the authors aimed to compare the efficacy and safety of infant prophylaxis with two drug regimens (lamivudine or lopinavir–ritonavir) to prevent postnatal HIV-1 transmission during up to 50 weeks of breastfeeding.

They did a randomised controlled trial in four sites in Burkina Faso, South Africa, Uganda, and Zambia in children born to HIV-infected mothers who were not yet eligible for antiretroviral therapy under the guidelines that existed when the trial took place (CD4 count >350 cells per μL —however, today, WHO advises that all people diagnosed with HIV immediately begin treatment, regardless of CD4 count).

In the study, HIV-negative breastfed infants aged 7 days were randomised to receive either lopinavir–ritonavir or lamivudine (paediatric liquid formulations, twice a day) up to 1 week after complete cessation of breastfeeding or at the final visit at week 50. Treatment allocation was hidden from

participants and study physicians, and the primary outcome was infant HIV-1 infection between age 7 days and 50 weeks, in the modified intention-to-treat population (meaning all babies in the study who attended at least one follow-up visit).

Between November, 2009, and May, 2012, 1273 infants were enrolled and 1236 were analysed; 615 assigned to lopinavir–ritonavir and 621 assigned to lamivudine. A total of 17 HIV infections were diagnosed in the study period (eight in the lopinavir–ritonavir group and nine in the lamivudine group), resulting in cumulative rates of HIV-1 infection of 1·4% and 1·5%, respectively, and meaning that infection rates did not differ between the two drug regimens. Clinical and biological severe adverse events did not differ between groups.

The authors say:

Crucially, about half of the postnatal HIV-1 infections in both groups occurred after 6 months of breastfeeding, while HIV exposure was much reduced during this period because of mixed feeding (lowering milk intakes) and some women stopping breastfeeding before 50 weeks. This finding justifies the extension of infant pre-exposure prophylaxis (PrEP) until the end of HIV exposure and the need to inform mothers about the persistent risk of transmission throughout breastfeeding to prevent them stopping giving the treatment to their babies too soon.

Further analysis of the data suggested that most of the HIV infections in the babies in both groups occurred because of lack of adherence to the study drug, rather than a failure of the drug to protect the baby once ingested. The authors say: “Drug adherence therefore remains a key factor for success of infant PrEP. More research is needed for more palatable oral paediatric formulations and long-acting injectable drugs.” The data showed that when the drug was actually taken, rates of HIV infection fell to 0·2% for the lopinavir–ritonavir group and 0·8% in the lamivudine group, respectively, again without a statistically significant difference between the groups.

The authors conclude:

Infant PrEP proved an effective and safe alternative to prevent postnatal HIV-1 transmission for mothers who are not ready or prepared to embark on long-term ART.

In addition, adding infant PrEP in breastfed babies whose mothers are taking ART is a strategy that should be assessed...At the population level, in countries where universal maternal ART cannot be implemented as recommended by WHO, infant PrEP with either lopinavir–ritonavir, lamivudine, or nevirapine for the whole duration of breastfeeding is also advisable.

Writing in a linked Comment, Professor Hoosen Coovadia, Maternal Adolescent and Child Health, School of Public Health, University of the Witwatersrand, Durban, South Africa and Dr Dhayendre Moodley, Center for the AIDS Programme of Research in South Africa and Women’s Health and HIV Research Unit, University of KwaZulu Natal, Durban, South Africa, say the data in this study show “that infant ART prophylaxis substantially decreases the breastfeeding risk of transmitting HIV, works at a scale greater than previously studied, and is effective and safe”.

View the story online: [Click here](#)

U.S. HIV Group Spends 25% of Time With High Viral Load

The Center for AIDS, as reported by The Body Pro | 12.1

More than 14,500 people in care in six U.S. clinics spent one quarter of their time with a viral load above 1500 copies.¹ A viral load that high raises chances of passing HIV to a sex partner and threatens the HIV-positive person's health. Study groups that spent more than one quarter of their time in care with a viral load above 1500 copies included blacks (26% of time), people 16 to 39 years old (32% of time), and people not taking antiretroviral therapy (58% of time).

HIV-positive people with an undetectable viral load -- below 40 or 50 copies per milliliter of blood -- rarely if ever pass HIV to a sex partner. Research shows that the risk of sexual HIV transmission rises when the viral load stands above 1500 copies.²⁻⁴ People with a viral load above 1500 copies usually have not started antiretroviral therapy, started treatment and missed a few doses or stopped entirely, or started an antiretroviral combination that's now failing.

Understanding how often the viral load of HIV-positive people in care stands above 1500 copies can give health authorities a better idea of how many positive people run a risk of passing HIV to their sex partner. Learning which groups of people are more likely to have a viral load above 1500 copies can help health officials and HIV providers work harder to get those people into care and onto steady, effective antiretroviral therapy.

For those reasons, researchers from the Centers for Disease Control and Prevention (CDC) and colleagues at the six U.S. clinics conducted this study to determine how much time HIV-positive people in care spend with a viral load above 1500 copies and how often viral loads are above that level in different HIV groups.

How the Study Worked

The study involved HIV-positive adults in care in at six clinics in six U.S. cities between April 2009 and March 2013. Everyone had at least two viral load tests during that time, with at least 30 days between the first test and the last test. The researchers called this group the observational cohort. Additional analyses to assess time with a viral load above 1500 copies according to antiretroviral therapy use involved a separate set of HIV-positive people enrolled in a clinical trial at the same six clinics. The researchers called these people the trial participants.

Total observation time for each person started with that person's first viral load test and ended with the last viral load test. The researchers calculated the percentage of time with a viral load above 1500 copies by determining the viral load between each pair of tests, in this manner:

- All days between two 1500-plus results were above-1500 days.
- All days between two sub-1500 results were sub-1500 days.
- If the viral load stood above 1500 copies on one test and below 1500 copies on the next, or the other way around, the researchers calculated days spent with a viral load above 1500 copies by a formula incorporating initial viral load, next viral load, and days between viral load measurements.

Next the CDC team divided observational cohort patients into several groups according to (1) percentage of viral load pairs with more than 6 months between the first and second, (2) years of entry into the analysis (2009-2010, 2010-2011, 2011-2012), (3) whether the first viral load was above 1500

copies, (4) age, (5) race/ethnicity, (6) sexual orientation, (7) injection drug use as an HIV exposure factor, (8) health insurance status, and (9) clinic site. For the trial participants, the researchers divided patients into groups according to (1) antiretroviral therapy status at entry to the study, (2) study group in the trial these people were participating in, (3) new or established patient, and (4) clinic site.

Finally, the research team used standard statistical methods to compare these groups according to time with a viral load above 1500 copies.

What the Study Found

The main study group (the observational cohort) included 14,532 HIV-positive people with two or more viral load measurements. About one third of this group was gay or bisexual men, another third heterosexual men, and another third women. Only 13% of study participants had injection drug use as a risk factor for becoming infected with HIV.

About one third of the group was 16 to 39 years old, one third 40 to 49, and one third 50 to 85. While 64% of study participants were black, 18% were Hispanic, and 17% white. More than 90% of these people had prescriptions for antiretroviral therapy during the 3 years from 2010 through 2012. About 15% of study participants had private insurance, 15% used Medicare, 25% used Medicaid, and the rest relied on Ryan White funding or charity. (Ryan White funding supports care for low-income, uninsured, and underinsured people with HIV and their families.)

Median observation time for the group (time between first and last viral load result) was 1073 days (almost 3 years), and study participants had a median of 9 viral load measures. Viral loads stood above 1500 copies an average 23% of the time per person, or 84 days per year per person.

Percentage of observation time with a viral load above 1500 copies varied a good deal across the different subgroups analyzed: Groups with the most time spent above the 1500-copy mark were those whose first viral load stood above 1500 copies (Figure 1), people for whom more than 25% of consecutive viral loads were measured more than 6 months apart (Figure 1), people whose CD4 count lay below 350 when their viral load was first measured (Figure 1), people 16 to 39 years old versus older (Figure 2), blacks versus whites (Figure 2), women and heterosexual men versus gay men (Figure 2), people who injected drugs (Figure 3), and people who did not have private insurance (Figure 3).

Statistical analysis that accounts for several viral load risk factors at the same time linked being in some of these groups with a longer time above 1500 copies, regardless of whatever other risk factors someone had. The analysis expresses differences between groups as an adjusted rate ratio (aRR). An aRR above 1.0 indicates longer time with a viral load above 1500 when comparing one group with another, and an aRR below 1.0 indicates shorter time with a viral load above 1500. For example, a rate ratio of 1.38 (16- to 39-year-olds versus 40- to 49-year-olds in the list below) means the younger groups spent 38% more time with a viral load above 1500 copies than the older group, regardless of other factors that might affect viral load.

- First measured viral load above 1500 versus below 1500: aRR 4.03
- More than 25% of viral load pairs measured more than 6 months apart versus 10% to 25% of viral load pairs measured more than 6 months apart: aRR 2.04
- More than 25% of viral load pairs measured more than 6 months apart versus fewer than 10% of viral load pairs measured more than 6 months apart: aRR 1.52
- CD4 count below 350 versus above 350 at first viral load measure: aRR 1.15

- 16 to 39 years old versus 50 to 85 years old: aRR 1.38
- 40 to 49 years old versus 50 to 85 years old: aRR 1.18
- Black versus white: aRR 1.24
- Gay/bisexual men versus heterosexual men: aRR 0.94 (6% less time spent above 1500 by gays)
- Injection drug use versus no injection drug use: aRR 1.21
- Ryan White/charity support versus private insurance: aRR 1.33
- Medicaid versus private insurance: aRR 1.40
- Medicare versus private insurance: aRR 1.29

The study included 1779 trial participants in the additional analysis of how antiretroviral use affected time spent with a viral load above 1500 copies. Trial participants were similar to the larger observational group (discussed just above) in age, sexual orientation, CD4 count, and most other factors except for race: 72% of trial participants were black, compared with 64% of the observational cohort. The median observation period in trial participants measured 1032 days, and these people had a median of 11 viral load measures.

Among all trial participants, viral load exceeded 1500 copies 26% of the time per person, or 95 days per year per person. This rate is similar to the 23% seen with the observational cohort (above). People not taking antiretroviral therapy when they entered the study period or in the next 12 months spent 58% of their time with a viral load above 1500 copies. In contrast, people who started antiretroviral therapy in the first 12 months of observation time spent 45% of their time with a viral load above 1500. And people already taking antiretrovirals when they entered the study spent 21% of their time with a viral load topping 1500. People who had just begun care at one of the six clinics spent 34% of their time with a viral load exceeding 1500 copies.

What the Results Mean for You

This large study of HIV-positive people in care in the United States found that they spent about 25% of the time with a viral load above 1500 copies -- even though 90% took antiretroviral therapy at some point. A viral load above 1500 copies signals a higher chance of passing HIV to a sex partner and so contributing to the almost 50,000 new HIV infections seen yearly in the United States. Time spent with a viral load above 1500 copies was even greater -- 58% -- in people not taking antiretroviral therapy.

Only about 10% of this study group did not take antiretroviral therapy during the study period. That low percentage reflects advice from U.S. HIV treatment experts, who recommend that everyone with HIV infection start therapy regardless of their CD4 count or viral load.⁵ Antiretroviral combinations available today are stronger, safer, and easier to take than combinations available 10 or 15 years ago. If everyone in this study group took antiretrovirals and didn't miss many doses, the average time spent with a viral load topping 1500 copies would be lower -- and so the group's overall risk of spreading HIV infection would be lower.

Besides this community-wide benefit of having a viral load below 1500, having a lower load (and higher CD4 count) cuts chances that the individual patient will get AIDS diseases and some non-AIDS diseases. The antiretroviral treatment goal for anyone taking antiretroviral therapy should be a viral load below 40 or 50 copies. A load that low means HIV has stopped multiplying in the body, although HIV remains in resting T cells and will become active again if antiretroviral therapy stops.

The study also identified several groups that spent more time with a viral load over 1500 than comparison groups:

- People not taking antiretrovirals (almost everyone not on treatment will have a detectable viral load, and often a high viral load)
- People who go a longer time between viral load measures (possibly because they are missing clinic appointments)
- People younger than 40 (a group that sometimes fails to take antiretroviral drugs regularly)
- Blacks (perhaps because of poor access to health care)
- People without private health insurance (who are poorer and so may have poor access to health care and more overall health problems than wealthier people)

Despite possible social and economic disadvantages, people in these groups should find the motivation to get care for their HIV infection, stay in care, start antiretroviral therapy, and take antiretrovirals on time, as their provider instructs. HIV providers can connect patients with a case manager, who will help with problems involving insurance, transportation, and child care. People who follow those steps are now living almost as long -- or as long as -- people without HIV infection. At the same time they're cutting the chance of passing HIV to sex partners.

A final note: having a low or undetectable viral load does not eliminate the chance of passing HIV to sex partners. Everyone with HIV should use condoms during sex -- to prevent transmission of HIV as well as other dangerous sexually transmitted infections. Condoms also protect the HIV-positive partner from picking up dangerous sexually transmitted diseases.

View the story and accompanying figures online: [Click here](#)

Mobile dating apps spur HIV epidemic among Asia's teenagers, says UN

Smartphone technology has increased the opportunities for casual sex and led to a spike in HIV infections among teenagers in Asia, researchers find

Oliver Holmes, The Guardian | 11.30

United Nations research has found the growing use of mobile dating apps by young gay men is a major factor in a new HIV epidemic among teenagers in Asia, the Guardian can reveal.

The report uncovered a surge of HIV infections among 10-19 years olds in the Asia-Pacific region, where more than half of the world's 1.2 billion adolescents live.

The two-year study found that smartphone dating apps have expanded the options for spontaneous casual sex as never before.

The epidemic is fastest growing amongst men who have sex with men. Other groups include those who are sexually exploited by or engaged in sex work, people who inject drugs, and young transgender people.

"Young gay men themselves have consistently told us that they are now using mobile dating apps to meet up for sex, and are having more casual sex with more people as a result. We know that this kind of risky behaviour increases the spread of HIV," said Wing-Sie Cheng, HIV/Aids adviser for Unicef in east Asia and the Pacific.

“We are therefore convinced that there is a link, and that we need to work better with mobile app providers to share information about HIV and protect the health of adolescents.”

The previously unreported epidemic threatens the UN’s goal to end the global Aids crisis by 2030, which appeared achievable after a sharp drop in Africa during the past 15 years.

Adolescents are also more likely to die of Aids-related deaths, researchers from Unicef and UNAIDS found, as they are less inclined to seek treatment, fearing they will be stigmatised or forced to expose their sexuality to their family or the authorities. In many countries in the region, under-18s cannot get an HIV test without parental consent.

While global HIV infections are falling, the number of adolescents aged 10-19 officially living with HIV in Asia and the Pacific has grown to more than 220,000, with the unofficial number expected to be much higher, Unicef says. Fewer than half of them are receiving treatment and deaths have risen nearly every year for a decade.

An HIV-positive Filipino man aged 30, speaking on condition of anonymity to protect himself from abuse, said it was hard to find sex for a gay teenager, bullied at school and closed off from the adult-only gay bars.

At university, the introduction of internet dating — chat rooms and online forums — allowed him to find more sexual partners his age. He would chat with men and agree to rent a room for a few hours in the capital.

“If I write down all the people I had sex with in Manila, I can probably write one to five people for each stop of the metro,” he said.

Smartphones and mobile dating revolutionised his sex life. Whereas internet dating involved a laborious process of arranging a meeting up, dating apps are location-based, allowing users to scan their surroundings for others.

“Even if you’re still in school and you feel the need to have sex, you just open Grindr,” he said. “You don’t even have to talk to them. People just send you naked photos or photos of their cocks. If you’re fine with them, you just go and have sex.”

The immediacy of the sex, organised in minutes, made condom use less likely, he said. “I did use condoms. But it was not consistent. You don’t want to lose the momentum.”

Despite his promiscuous mobile dating years, the Filipino man’s HIV test returned negative and he entered into a long-term relationship. But two years later he contracted the virus from his boyfriend who was secretly cheating on him by using mobile dating apps.

In the Philippines, new HIV infections among teenagers have doubled in four years. In Bangkok, young gay men now have a one in three chance of HIV infection.

And eighteen countries across the Asia-Pacific region criminalise against same-sex relationships — which UNAIDS says causes gay men to avoid life-saving HIV services.

A separate study last year found that men who have sex with men using dating apps are at greater risk of contracting gonorrhoea and chlamydia than those who meet in-person or on the internet.

Wing-Sie, the Unicef adviser, said that dating apps create networks of men, in which infections rapidly spread among users. "Mobile dating apps essentially hook you up to a central network."

She said the study looked at observational trends around the region reported by United Nations officers and local community workers who said their HIV strategy urgently needed to adapt to the explosion of mobile dating apps. "HIV is a covert issue, it is very hidden. So data is not available."

She said researchers found "that with the rise of these apps, the probability and risk of infection will increase multifold because it makes it so much easier for them to date other guys and hook up for sex," she said.

A spokesman from Grindr, used in 196 countries worldwide with 1 million active users every minute, said it has a minimum age requirement of 18. "As the world's largest gay platform, we take matters of sexual health very seriously," the spokesman said, adding that Grindr runs in-app announcements encouraging testing at local clinics.

David S Novak, senior health strategist at Online Buddies, the parent company of the dating app Jack'd, directed the Guardian to its ManHunt Cares project, which provides health resources to its users. In 2009, the company also set up a research institute focusing on gay sexual health.

Other major dating app companies Tinder, Blued and Growlr did not respond to requests for comment.

The UN report says these apps can become vital conduits promoting sexual health, including HIV messaging and testing, and references a 2014 World Aids Day project by the Chinese gay dating app Blued where a red ribbon was added next to every user's profile picture, linking to details of nearby testing centres.

Wing-Sie said Unicef will approach mobile dating app companies in the coming months for a "collaborative effort" and so the world body might collect data to further investigate the impact of mobile dating.

Based in Bangkok, Jesse Krisintu has been working with charities trying to persuade young people to get tested for HIV through tactics such as pop-up advertisements on dating apps. He said the project did not work.

"It's their business. If they advertise too much about HIV/Aids services there, do you think people are going to go online?" he said.

He said that one project involving pop-ups offered discounts on HIV tests but that very few were claimed and that the analytics shows most users immediately closed the pop-up advert.

"The application is where the key population is but no one is going to read the pop-up because the purpose of people going to those apps to find sex, not to find knowledge. The results are not that favourable," he said. "People just close it."

The UN is now also advocating for comprehensive sex education — beyond a simple explanation of the sex organs — and for reducing the age at which adolescents can take an HIV test without parental consent.

AIDS is already the leading cause of death for adolescents in Africa and the second leading cause of death among adolescents globally, tripling over the past 15 years and mostly as a result of mother-to-child transmission. However, this new breed of epidemic found in Asia-Pacific could be replicated elsewhere, public health officials warn.

“There is a risk of not being able to eliminate Aids at all,” Wing-Sie said. “This is the new frontier of Aids to tackle right now. The world can never end Aids if this issue is not controlled.”

View the story and accompanying charts online: [Click here](#)

COMMENTARY: Jack Mackenroth, the Global Forum on MSM & HIV, and Hornet vs. HIV

Jack Mackenroth, Advocate.com | 12.1

Blue Ribbon Boys is a progressive, sex-positive, HIV viral suppression campaign that encourages dating/hookup app users to protect their sexual health. It's a forward-thinking partnership between the Global Forum on MSM and HIV and the gay app Hornet. It's particularly innovative because it is inclusive of all men who have sex with men, regardless of HIV status. The campaign will reach 7.5 million MSM around the world using cutting-edge technology and modern messaging.

Blue Ribbon Boys prompts Hornet users to answer a short series of yes or no questions about their sexual health. Based on their answers, those who qualify receive a blue ribbon icon on their profile photo signifying their personal commitment to health and HIV viral suppression, irrespective of their HIV status. Men who do not meet the standard are directed to information and ways to protect and improve their sexual health so they can become a Blue Ribbon Boy. Users will refresh their answers every three months.

This campaign is launched at a time when prevention messages for men who have sex with men urgently need refreshing. Past public health messages for MSM were typically framed as directives that utilize shame, blame, or fear tactics to motivate compliance with recommendations developed by officials with good intentions. Developed by and for men who have sex with men, Blue Ribbon Boys modernizes the message by reintroducing sex into the message and by informing men about the fuller range of prevention options available to them. Those options now include the early and consistent use of antiretroviral medications. Blue Ribbon Boys actively promotes early initiation of antiretroviral medications for HIV-positive men and widespread use of pre-exposure prophylaxis among HIV-negative men. When these options are not easily available or accessible, Blue Ribbon Boys encourages men to demand them and to seek out other strategies.

Blue Ribbon Boys replaces directions with questions posed to users. Questions focus on HIV and STI testing, antiretroviral treatment, PrEP, HIV status and viral load, disclosure, stigma, and other protection and prevention methods. The blue ribbon icon pays homage to the red AIDS ribbon combined with the color of the pill first approved for use as PrEP.

The goal of Blue Ribbon Boys is global HIV viral suppression. To accomplish this, Hornet users are reminded about the importance of:

- Regular HIV testing
- PrEP for HIV-negative men at “significant” risk for HIV infection
- Early and consistent use of antiretroviral medications for men who are living with HIV, with the aim of suppressing HIV viral load and maintaining “undetectable” status
- Condoms and lubricant during anal sex
- Up-to-date Information about local resources and services

Blue Ribbon Boys emphasizes HIV viral suppression as everyone’s responsibility without passing moral judgment. It does not call out or differentiate between HIV-positive or HIV-negative men who have sex with men. It is inclusive, circumventing the stigma that is still associated with a positive HIV status or with taking PrEP. Guys who become Blue Ribbon Boys are standing proudly as advocates for global HIV viral suppression and sexual health. Individual HIV status is confidential and inconsequential for participation in the campaign.

Blue Ribbon Boys is globally ambitious because it reaches MSM in countries where basic services may not be available but the prevalence of smartphones is widespread. It also directly targets young MSM who are early adopters of technology and are often at highest risk for HIV. Young people (under 25) represent over 40 percent of new HIV infections worldwide. Hornet users who hit a roadblock in their attempt to access basic sexual health services will be directed to two global petitions. One is for HIV-negative men who want access to PrEP and other prevention services. The second is for HIV-positive men who demand unfettered access to antiretroviral treatment.

Globally, Hornet is the second largest MSM social app after Grindr, with over 7.5 million users, and is the leading gay app in many countries where HIV is concentrated among MSM. Hornet is the most popular gay app in Brazil, Turkey, Russia, Thailand, Taiwan, Egypt, and the Philippines. Hornet also has a large footprint in Latin America, Asia, and a small but growing member base in parts of Africa. Hornet prides itself on innovating the most advanced platform interface with constant updates to improve the user experience. It has been at the forefront of sexual health activism and has previously implemented several features and programs that provide information and sexual health services to their users.

As the climate of HIV is rapidly changing across the globe, mobile apps that can rapidly adapt are integral in the future of HIV and sexual health messaging. Wherever you are in the world, having clear and accurate information is vital in the fight against HIV and AIDS. It enables individuals and communities affected by HIV to protect themselves, care for others, advocate for better services and challenge stigma and discrimination.

Repositioning the global HIV prevention message to focus on viral suppression is a modern, empowering narrative that encourages community participation. It is not fear-based. It is inclusive and reminds us all that by protecting ourselves, regardless of our HIV status, we are also protecting the greater community.

View the story online: [Click here](#)

Scientific Papers/Conference Abstracts

PERSPECTIVE: Ending the HIV–AIDS Pandemic — Follow the Science

Facu AS, Marston HD. *NEJM* 2015;373:2197-2199

WHAT:

For many years, clinicians debated the best time to start antiretroviral therapy (ART) for HIV infection, with some worrying that the risks of treatment in terms of drug toxicities could outweigh the benefits of controlling the virus. In a new commentary, scientists from the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health, argue that the results of three large clinical trials definitively prove that the benefits of starting ART early in infection outweigh any theoretical risk. Together, the findings from the NIH-funded SMART study reported in 2006, HPTN 052 study in 2011 and START study this year conclusively demonstrate that starting ART promptly after HIV diagnosis protects the health of the infected individual while preventing HIV transmission to uninfected sexual partners, the authors write.

NIAID Director Anthony S. Fauci, M.D., and colleague Hilary D. Marston, M.D., M.P.H., also note that the results of the IPERGAY study, published concurrently with their commentary today online by the New England Journal of Medicine, represent important new data on HIV prevention. The study, conducted in France and Canada, focused on the use of ART for HIV prevention, a practice known as pre-exposure prophylaxis (PrEP). The IPERGAY researchers found that men who have sex with men and transgender women at high risk for HIV infection who took PrEP around the time of sexual activity were 86 percent less likely to acquire HIV than similar individuals who took a placebo. According to Drs. Fauci and Marston, this finding is further evidence of the power of PrEP to prevent HIV infection in high-risk populations. The combination of PrEP and prompt initiation of ART for infected individuals offers a promising blueprint to bring about an end to the HIV/AIDS pandemic, the authors write.

Now, the scientists conclude, realizing the promise of early ART and PrEP depends on whether sufficient global political will can be mustered to provide sufficient human and financial resources to scale up HIV testing and treatment throughout the world.

View the paper online: [Full paper](#)

Assessing the Changing Landscape of Sexual Health Clinical Service After the Implementation of the Affordable Care Act

Mettenbrink C, Al-Tayyib A, Eggert J, et al. *Sex Transm Dis* 2015;42(12):725-730

Introduction:

Federal health reform has the potential to impact many public health services, especially sexual health clinics. To assess the impact of such reform within the Denver Sexual Health Clinic (DSHC), we conducted a survey of patients to better understand our client population and their care-seeking behavior.

Methods:

Survey data were collected from patients attending the DSHC at 3 different points in time to ascertain insurance status, reasons for not having insurance, reasons for choosing care at the DSHC, and health care use over the past 12 months.

Results:

A total of 1603 surveys were completed. Forty-two percent of participants were enrolled in health insurance at the time of visit. The percentage of patients with Medicaid increased more than 200% across the survey cycles. Cost was the main reason cited for not having insurance. Participants identified confidentiality and convenience among the top reasons for seeking care at the DSHC regardless of sex or insurance. Although there was no difference in health care use for sexual health services, individuals with health insurance were more likely to have used nonsexual health services in the past 12 months than those without insurance.

Conclusions:

Patients continue to visit the DSHC despite having health insurance. Sexual health clinics must work to understand what drives people to seek care so that they can better prepare for the future.

View the paper online: [Full paper](#)

Evaluating Quality of Care for Sexually Transmitted Infections in Different Clinical Settings

Sequeira S, Morgan JR, Fagan M, et al. *Sex Transm Dis* 2015;42(12):717-724

Background:

We examined quality of care across different clinical settings within a large safety-net hospital in Massachusetts for patients presenting with penile discharge/dysuria or vaginal discharge.

Methods:

Using a modified Delphi approach, a list of sex-specific sexually transmitted infection (STI) quality measures, covering 7 domains of clinical care (history, examination, laboratory testing, assessment, treatment, additional screening, counseling), was selected as standard of care by a panel of 5 STI experts representing emergency department (ED), obstetrics/gynecology (Ob/Gyn), family medicine (FM), primary care (PC), and infectious disease. Final measures were piloted with 50 charts per sex from the STI Clinic and age, sex, and visit date-matched charts from PC, FM, ED, and Ob/Gyn. Performance was scored as compliance among individual measures within 7 domains, standardized to add up to one to adjust for variable number of measures per domain, with an overall score of 7 indicating complete adherence to standards.

Results:

Expert review process took 2 weeks and resulted in 24 and 34 final measures for male and female patients, respectively. Performance on 7 clinical domains ranged from 3.16 to 4.36 for male patients and 3.17 to 4.33 for female patients. Sexually transmitted infection clinic seemed to score higher on

laboratory testing, additional screening, and counseling, but lower on examination and assessment, and ED seemed to score higher on examination and treatment, PC and FM on laboratory testing for male patients and on examination and treatment for female patients, and Ob/Gyn on treatment.

Conclusions:

An instrument to discern standard of care and identify strengths and weaknesses in specific domains of clinical documentation for patients presenting with STI complaints can be developed and implemented for quality evaluation across care settings. Further research is needed on whether these findings can be integrated into site-specific quality improvement processes and linked to cost analyses.

View the paper online: [Full paper](#)

Resources, Webinars, & Announcements

STD Prevention Conference Call for Abstracts to Open Soon

Get your abstracts ready! The STD Prevention Conference Scientific Program Committee will soon open the abstract submission system and provide information regarding Conference Tracks and Domains. The 2016 conference theme will focus on identifying and transforming barriers into opportunities for moving STD prevention forward. The Committee has shared this helpful resource on "[How to Write an Abstract](#)" to help guide you through the process.

BLOG: Be Empowered: Know The Facts First

Nancy C. Lee, Office of Women's Health

Talking about sex isn't always easy, especially with your kids. It's awkward, but having the talk can help them be smart about sex and relationships. The key to these conversations is accurate information. [Know The Facts First](#), a public health awareness campaign, is aimed at just that: providing teen girls 13 to 19 with accurate information about sexual health, sexually transmitted infections (STIs), and STI prevention so that they can make informed decisions. Our campaign is also relevant to teen boys who face the same kinds of questions, worries, and pressures about sex as teen girls.

We want all teens to *Know The Facts First*. No fiction, [just the facts](#).

About 1 in 4 teens has an STI. That fact, and the reality that so much sexual health information is clouded in myth and confusion, led us at the Office on Women's Health (OWH) to develop *Know The Facts First* with the National Alliance of State and Territorial AIDS Directors and the National Coalition of STD Directors. Starting today at KnowTheFactsFirst.gov, teens — and even parents and other adults — have a place to get reliable, straightforward information. In addition to abstinence, they can find out about the different STIs, how to prevent them, and where to get tested. They can learn to separate truth from myth. With this information, teens will have the facts they need to ask the right questions, engage in healthy conversations, access the best resources, and feel empowered to protect themselves from STIs.

I wish [Know The Facts First](#) had been available when my daughter was a teen, but I'm thrilled this easy-to-understand information is now available for teens today. We're excited to kick off *Know The Facts First* and share this vital information with you. Get the latest info on Twitter by following [#KTFE](#), and follow us at [@girlshealth](#) and [@womenshealth](#).

For more information: [Click here](#)

Updated National HIV/AIDS Strategy Federal Action Plan Includes Key Sex Ed Activities

SIECUS | 12.1

Today, World AIDS Day, the White House released the [National HIV/AIDS Strategy: Updated to 2020](#) (NHAS 2020) [Federal Action Plan](#). As [previously reported](#) by SIECUS, NHAS 2020 builds upon President Obama's 2010 National HIV/AIDS Strategy, the first-ever in U.S. history, emphasizing the importance of sexuality education for young people and "across generations." Additionally, NHAS 2020 addresses the role that parents, communities, and schools play in providing sexual health information and tools within "safe, inclusive, and destigmatizing" environments.

The [NHAS 2020 Federal Action Plan](#) includes the immediate fiscal year (2016), and the longer term, three–five years, actions for federal agencies to achieve "toward improving HIV prevention and care outcomes." Not intended to be an exhaustive list of federal activities related to NHAS 2020, the Federal Action Plan identifies "strategic actions designed to help achieve the goals and measurable outcomes...of the Strategy."

There is much to applaud within the [Federal Action Plan](#) supporting the goals of 1) reducing new HIV infections; 2) increasing access to care and improving health outcomes for people living with HIV; 3) reducing HIV-related disparities and health inequities; and 4) achieving a more coordinated national response to the HIV epidemic.

SIECUS is particularly pleased to highlight the action items related to the goal of reducing new HIV infections. Under this goal, step 1.C.3 calls to "promote age-appropriate HIV and STI prevention education for all Americans" over the next five years. This specifically includes agency action to promote and expand sexual health education in schools through the leadership of the Department of Education and the Centers for Disease Control and Prevention (CDC).

In addition, agency partnerships such as the Office of Adolescent Health (OAH), the Administration for Children and Families (ACF), the Office of Population Affairs (OPA), among others, will lead various activities to provide evidence-based resources, campaigns, and education programs particularly focused on reaching those most often marginalized.

The [Federal Action Plan](#) provides critical leadership activity toward achieving the goals of NHAS 2020, but it will take nationwide partnerships to fulfill the vision of NHAS 2020. SIECUS looks forward to working with our federal, national, state, and local partners to achieve these actions and more to advance sexuality education and improve the sexual health of all people.

Job/Internship Postings

Mobile Testing Venue Coordinator – SF AIDS Foundation

Organization: San Francisco AIDS Foundation
Location: San Francisco

POSITION SUMMARY:

The Testing Coordinator's duties include overseeing venue based testing shifts done in conjunction with SFAF Mobile Testing Unit (MTU). This includes scheduling weekly shifts, managing staff and volunteers, reserving parking, and coordinating testing protocols with Testing Services Manager. Additionally, the testing coordinator will manage the Foundation's city-wide condom distribution program and manage the Outreach program.

ESSENTIAL DUTIES AND RESPONSIBILITIES

Include the following. Other duties may be assigned.

1. Manage day to day operations for MTU including insuring that maintenance is done, staffing patterns are sufficient and in accordance with policies and procedures, and ensure that contractual obligations are being met.
2. Monitors and evaluates MTU initiatives and makes appropriate adjustments to meet contract goals
3. Supervise and work with MTU staff or volunteers to ensure their accuracy and competency.
4. Train new volunteers and staff conducting HIV/STI/HCV testing
5. Perform phlebotomy and HIV Test Counseling services as needed to conduct HIV/HCV antibody and confirmatory testing.
6. Coordinate day to day operation for city-wide condom distribution program.
7. Develop and maintain relationships with current and potential venues for both condom distribution and testing activities.
8. In conjunction with the Director of Program Development & Operations, manage day to day operation of the Outreach Team ensuring that staffing patterns are sufficient and that contractual obligations are being met.

Other Skills and Abilities: Excellent oral and written communication skills required. Strong people and phone skills. Strong organizational skills. Comfort with sexually explicit material and language. Ability to prioritize and work under deadlines. Detail oriented and some familiarity with surveys/evaluation helpful. Comfort with multi-tasking and basic budgetary skills. Accurate typing and data entry skills. Familiarity and comfort with diverse communities including Substance Users, LGBT and Homeless populations.

EDUCATION AND/OR EXPERIENCE:

A bachelor's degree and 2 years' experience in an administrative capacity in a public health organization or an equivalent combination of education and experience. Proof of valid California driver's license with

excellent driving record and driver's insurance required. California Phlebotomy License & California HIV Test Counselor Certification highly preferred.

PHYSICAL DEMANDS:

Skill in operating office equipment such as a personal computer, copy machine and telephone system. Ability to perform routine bending, stooping, twisting, and reaching. The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

WORK ENVIRONMENT:

This position is primarily located 1035 Market Street, San Francisco, however requires frequent travel to other office locations or off-site testing shifts and meetings as required by the job. This position requires work in the evenings and weekends.

The statements herein are intended to describe the general nature and level of work being performed by employees assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties, and skills required for personnel so classified.

EQUAL EMPLOYMENT OPPORTUNITY STATEMENT:

The San Francisco AIDS Foundation is an Equal Opportunity employer. We actively seek applications from people living with HIV/AIDS, or disabilities, as well as women, trans-individuals, LGBQQIA individuals and people of color.

Pursuant to the San Francisco Fair Chance Ordinance, we will consider for employment qualified applicants with arrest and conviction records.

For more information: [Click here](#)

Aaron Kavanaugh

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