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California Stories

HIV monitoring tools improve progress locally in California

Stephanie Viguers, Healio Infectious Disease News | 12.9

Local health jurisdictions in California that used evaluation tools to monitor progress in HIV reported incremental improvements in identifying new cases and expanding testing to high-to-moderate risk populations, according to data presented at the CDC's National HIV Prevention Conference.

In 2010, the White House established goals for the HIV/AIDS strategy to reduce new cases of HIV, increase access to care, reduce health disparities and refine the national response. To meet these goals with limited funding, Deanna L. Sykes, PhD, from the California Department of Public Health, Office of AIDS, and colleagues developed a cost-effective approach using evaluation tools that monitor progress in the state where approximately 5,000 new HIV cases are diagnosed annually. The tools included an automated report that tracks progress in HIV, a companion worksheet comparing performance with goals and a data-driven communication.

Sykes and colleagues distributed the tools to HIV prevention providers in 19 local jurisdictions and developed prevention objectives for each jurisdiction based on HIV burden. Researchers communicated the goals through an interactive worksheet that displayed the proportion of statewide goals each jurisdiction was responsible for achieving. The jurisdictions were encouraged to use the tools to assess their progress and adjust midyear performances when needed.

Steady progress was observed across the jurisdictions over a 3-year duration, according to the researchers. HIV diagnoses increased from 0.61% in 2011 to 0.69% in 2012, 0.87% in 2013 and 0.88% in 2014. In addition, the number of tests offered to high-to-moderate risk populations increased from 47% in 2011 and 2012 to 49% in 2013 and 56% in 2014.

Sykes and colleagues concluded the tools can provide a positive impact on local goals and offer providers the opportunity to increase prevention efforts.

Reference:

Sykes D, et al. Abstract 2224. Presented at: National HIV Prevention Conference; Dec. 6-9, 2015; Atlanta.

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

Rise in STDs inspires sex-ed discussion

Ana B. Ibarra, Merced Sun-Star | 12.8

Reported U.S. cases of chlamydia, gonorrhea and syphilis have increased for the first time since 2006, igniting, once again, conversation about the importance of comprehensive sex education.

According to a report from the Centers for Disease Control and Prevention released last month, cases of chlamydia rose 2.8 percent from 2013 to 2014, bringing the national rate of infection to 456.1 cases per 100,000 people.

While less common, rates of syphilis and gonorrhea also have increased since 2013. Syphilis cases rose by 15.1 percent to 6.3 cases per 100,000 people; incidents of gonorrhea rose 5.1 percent to 110.7 cases per 100,000 people.

In Merced County, the rate of chlamydia was reported at 389 cases per 100,000 people, according to 2014 data from the California Department of Public Health. The rate is lower than the state average rate of 453.4 per 100,000.

Kern, San Francisco and Fresno counties have the highest rates in the state, according to data released this year by the state health department.

People ages 20 to 24 are affected the most. People in this age group, for example, account for 41 percent of all reported chlamydia cases in Merced County.

“The consequences of STDs are especially severe for young people,” said Gail Bolan, M.D., director of CDC’s Division of STD Prevention, in a news release. “Because chlamydia and gonorrhea often have no symptoms, many infections go undiagnosed, and this can lead to lifelong repercussions for a woman’s reproductive health, including pelvic inflammatory disease and infertility.”

Local health educators are hopeful a new state law, which will mandate comprehensive sex education in middle schools and high schools, will help lower the rate of sexually transmitted diseases in the Valley.

Desirre Herrera, regional program manager of education services for Planned Parenthood Mar Monte, supervises education programs in the Central Valley from Kern County all the way north to San Joaquin County. A lack of medically accurate information, especially among younger people, is something she sees throughout the area.

“In Merced County, like in many Valley counties, we see a spike for a number of reasons, but a key issue is that people don’t get tested, and if they don’t get tested, they won’t know they are infected, and they won’t get treated,” she said.

Until recently, comprehensive sexual health education had not been mandated at schools. But this will change beginning Jan. 1.

The California Healthy Youth Act, signed by Gov. Jerry Brown earlier this year, updates instruction provided in schools to cover more than only HIV prevention. Comprehensive sexual health education, Herrera said, will include medically accurate information on STDs; options for protection, such as birth control and condoms; and clinical access, such as how to get tested and where.

The information also addresses abstinence, refusal skills and healthy relationships. The new law also requires the information to be LGBT inclusive.

The Central Valley, Herrera said, tends to be more conservative, and not all schools provide comprehensive sex education.

“This impacts the decisions teens and young adults make,” she said.

Herrera expects the new law to help lower STD rates and the rate of teen pregnancy in the Valley. But it will take some time to see results, she said.

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National Stories

HIV diagnoses decline almost 20 percent, but progress is uneven

Press Release, CDC NCHSTP | 12.6

Annual HIV diagnoses in the United States fell by 19 percent from 2005 to 2014, driven by dramatic and continuing declines over the decade among several populations including heterosexuals, people who inject drugs, and African Americans – with the steepest declines among black women. However, the same level of success was not seen among all gay and bisexual men.

For gay and bisexual men, trends over the decade have varied by race and ethnicity. Among white gay and bisexual men, diagnoses dropped steadily, decreasing 18 percent. Diagnoses among Latino gay and bisexual men continued to rise and were up 24 percent. Diagnoses among black gay and bisexual men also increased (22 percent) between 2005 and 2014, but that increase has leveled off since 2010.

A similar trend was seen among young black gay and bisexual men ages 13-24, who experienced a steep 87 percent increase in diagnoses between 2005 and 2014. Between 2010 and 2014, however, the trend has leveled off (with a 2 percent decline).

“Although we are encouraged by the recent slowing of the epidemic among black gay and bisexual men – especially young men – they continue to face a disproportionately high HIV burden and we must address it,” said Jonathan Mermin, M.D., director of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. “Much more must be done to reduce new infections and to reverse the increases among Latino men. There is hope that the National HIV/AIDS Strategy and other efforts are beginning to pay off, but we can’t rest until we see equal gains for all races and risk groups.”

The new national analyses examined trends in diagnoses over two time periods, 2005-2014 and 2010-2014, to provide both a decade-long perspective as well as a more recent view of trends. Among the findings:

- From 2005-2014, the annual number of HIV diagnoses in the U.S. declined 19 percent (from 48,795 to 39,718 per year) – driven by substantial declines among heterosexuals (down 35 percent) and people who inject drugs (down 63 percent).
- HIV diagnoses among black women were cut nearly in half, from 8,020 to 4,623 over the 2005-2014 period (42 percent decline), with continuing declines in recent years (25 percent since 2010).
- Diagnoses among gay and bisexual men overall increased about 6 percent over the decade (from 25,155 to 26,612), but stabilized in more recent years (a less than 1 percent increase from 26,386 to 26,612).
- Among white gay and bisexual men, diagnoses dropped steadily – both over the decade (decreasing 18 percent from 9,966 to 8,207) and in more recent years (decreasing 6 percent from 8,766 to 8,207).
- Over the decade, diagnoses among black gay and bisexual men increased by 22 percent (from 8,235 to 10,080) but stabilized in more recent years (a less than 1 percent increase, from 10,013 to 10,080).
- Further, while black gay and bisexual men ages 13-24 experienced a steep increase (87 percent from 2,094 to 3,923) in diagnoses over the decade, diagnoses among young black gay and bisexual men actually declined by 2 percent (from 3,994 to 3,923) in the most recent years.

- Finally, diagnoses continued to increase among Latino gay and bisexual men – both over the decade (by 24 percent from 5,492 to 6,829) and in more recent years (by 13 percent from 6,060 to 6,829).

HIV testing remained stable or increased among the groups experiencing declines in diagnoses in recent years. Researchers therefore believe the decreases in diagnoses reflect a decline in new infections. Similarly, because HIV testing remained stable among Latino gay and bisexual men during this period, the increases in HIV diagnoses suggest infections are likely increasing in this group.

“The recent five-year trends coincide with the launch of the first [National HIV/AIDS Strategy](#) and – now that the investment in high-impact prevention approaches has increased – offer promise for further progress,” said Eugene McCray, M.D., director of CDC’s Division of HIV/AIDS Prevention. “We have the tools to stop HIV right now. We urgently need to accelerate access to testing, treatment, and new biomedical prevention strategies so that everyone can protect themselves and their partners.”

Dr. McCray today announced the analysis of HIV diagnosis trends during his plenary speech launching the National HIV Prevention Conference. The 2015 National HIV Prevention Conference, convened by the CDC and many public, private, and government agencies, will take place in Atlanta, Dec. 6-9. This meeting focuses on the full spectrum of HIV prevention, giving community organizations, public health professionals, clinicians, advocates, and other interested individuals the opportunity to exchange information about effective prevention approaches. For more information about the conference, please visit www.cdc.gov/nhpc(<http://www.cdc.gov/nhpc/index.html>).

For additional information, visit

www.cdc.gov/nchhstp/newsroom(<http://www.cdc.gov/nchhstp/newsroom/default.html>).

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U.S. HIV Diagnoses Show Some Signs of a Slowing Epidemic

Benjamin Ryan, POZ.com | 12.7

The U.S. HIV diagnosis rate dropped by 19 percent during the past decade, although such encouraging news is tempered by the uneven progress seen among different risk groups. The Centers for Disease Control and Prevention (CDC) conducted an analysis of HIV diagnoses (as opposed to estimated transmissions of the virus) among various populations between 2005 and 2014 as well as from 2010 to 2014. Findings were presented at the 2015 National HIV Prevention Conference in Atlanta.

Since 2005, HIV diagnoses have declined among heterosexuals, injection drug users and African Americans, in particular among black women. Success has been uneven among men who have sex with men (MSM). Among MSM as a whole, HIV rates have risen during the past decade, specifically among blacks and Latinos; whites’ rates have dropped. Young MSM of all races saw steep increases. There are encouraging signs, however, that the rates for MSM as a whole, including young MSM, have recently begun to level off.

Annual HIV diagnoses are not necessarily a close indicator of how many new transmissions occur each year. If HIV testing rates rise, this may give the impression that there have been more recent transmissions than is actually the case. People with HIV may have been living for the virus for many

years before they get tested, so a positive test does not always indicate a recent transmission. Still, because HIV testing rates have remained stable or increased among the various groups considered in the CDC analysis, the health agency believes its diagnosis data does reflect an overall drop in new infections. Also, because testing rates among Latino MSM have remained stable, the CDC believes that a recent increase in HIV diagnoses among that group points to an actual upswing in recent infections.

Although we are encouraged by the recent slowing of the epidemic among black gay and bisexual men—especially young men—they continue to face a disproportionately high HIV burden and we must address it,” Jonathan Mermin, MD, director of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, said in a press release. “Much more must be done to reduce new infections and to reverse the increases among Latino men.”

About 40,000 Americans are diagnosed with HIV annually.

HIV diagnoses among women dropped 40 percent between 2005 and 2014, from 12,499 to 7,533. African-American women saw a 42 percent decline in the HIV diagnosis rate during that time; during the 2005 to 2014 period, they experienced a 25 drop in diagnoses. About six in 10 new diagnoses among women currently occur in African-American women.

The 10-year diagnosis rate decline for men was more measured at 11 percent, dropping from 36,296 to 32,185, on account of the stubborn rate among MSM.

Two-thirds of HIV diagnoses in 2014 were among MSM. From 2005 to 2014, the diagnosis rate increased about 6 percent among all MSM, from 25,155 to 26,612. The trends were mixed based on race. The diagnosis rate increased 24 percent among Latino MSM, from 5,492 to 6,829, and 22 percent among black MSM, from 8,235 to 10,080, while dropping 18 percent among white MSM, from 9,966 to 8,207. MSM 13 to 24 years old saw the steepest increases: The diagnosis rate increased 87 percent among both black and Latino young MSM, from 2,094 to 3,923 and from 866 to 1,617, respectively, and rose 56 percent among young white MSM, from 756 to 1,179.

Looking just at the diagnosis rates between 2010 and 2014, the CDC found more encouraging signs of a leveling off among MSM. Diagnoses increased less than 1 percent among the group as a whole, from 26,386 to 26,612, and there was a comparably small rate of increase among black MSM, from 10,013 to 10,080. However, diagnoses increased 13 percent among Latino MSM, from 6,060 to 6,829. Diagnoses have also recently stabilized among white and black 13-to-24-year-old MSM, with a 2 percent decline among young black MSM, from 3,882 to 3,923, and a less than 1 percent decline among young white MSM, from 1,186 to 1,179. Diagnoses are still rising among young Latino MSM, though the rate of change during the 2010 to 2014 period was slower than during the previous part of the past decade. Latino MSM’s diagnosis rate saw a 16 percent increase between 2010 and 2014, from 1,383 to 1,617.

When asked about possible explanations for the apparent recent progress in the HIV epidemic among MSM, specifically if the advent of Truvada (tenofovir/emtricitabine) as pre-exposure prophylaxis (PrEP) may have played a significant role, Eugene McCray, MD, director of the Division of HIV/AIDS Prevention at CDC, said, "It is less likely that the leveling off is a direct result of any single intervention, and far more likely to be the result of a combination of prevention efforts." He then added, "We must continue risk reduction education, increasing the number of people who know their HIV status, encourage consistent and correct condom use--for those who can consistently use them, increase awareness of PrEP, and

continue to ensure that those living with HIV have access to quality care that protects their health and helps prevent transmission to their partners.”

PrEP was approved in the United States in July 2012, but use was scant for the first year. After a flood of media attention about the HIV prevention method during late 2013, HIV-negative Americans began taking Truvada in increasing numbers. According to a rough estimate, about 22,000 people were using PrEP at the beginning of 2015, most of them MSM.

African Americans, representing 13 percent of the U.S. population, comprised 44 percent of HIV diagnoses in 2014. And while Latinos make up 17 percent of the population, 23 percent of new diagnoses occurred among that group.

To read the CDC press release on the report, [click here](#).

To read a CDC fact sheet on 2010 to 2014 diagnosis trends, [click here](#).

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

Men with HIV engaging in risky sexual behavior

Yvette Brazier, Medical News Today | 12.7

Human immunodeficiency virus (HIV) continues to affect men who have sex with men (MSM) more than other populations in the US.

Recent data from the US Centers for Disease Control and Prevention (CDC) suggests that the HIV epidemic is growing among MSM, while remaining relatively stable in heterosexual populations.

Young MSM, or YMSM, aged 13-29 years, are particularly vulnerable to HIV, accounting for more than 25% of new infections in the US, and more than 70% of all new HIV infections among youths.

Black YMSM are disproportionately affected, accounting for 61% of all new HIV infections in the US in 2009. Young transgender women are also at risk, with more than 20% of new HIV cases reported in this subgroup.

Methods and aims of HIV treatment

HIV testing, antiretroviral treatment, adherence and viral suppression among YMSM with HIV play a key role in preventing new infections.

Treatment for HIV aims to decrease the level of virus in the blood to an undetectable viral load. If a person has a detectable viral load, this means the amount of virus in the blood is high enough to be reliably detected; a cut-off point is fixed, below which the virus is said to be undetectable.

It is thought that behavioral approaches, together with interventions to reduce risky sexual behaviors, could help improve rates of engagement in care and adherence to medication. Risky sexual behavior includes condomless anal intercourse (CAI).

Patrick A. Wilson, PhD, of the Columbia University Mailman School of Public Health in New York, and coauthors examined differences in demographic and psychosocial factors between YMSM with and without a detectable viral load for HIV.

The team also looked at psychosocial factors associated with CAI and CAI among YMSM with detectable viral load.

The authors studied 991 YMSM with a detectable viral load, aged 15-26, at 20 adolescent HIV clinics in the US from 2009-12.

Higher CAI activity among those with detectable HIV

Among these participants, 69.4% had a detectable HIV viral load; 46.2% reported CAI in the past 3 months, and 31.3% reported CAI with someone of a different HIV status.

More than half (54.7%) of YMSM with detectable HIV reported CAI, compared with 44.4% of those who were virologically suppressed, or without detectable HIV.

Likewise, 34.9% of YMSM with detectable HIV reported CAI with a partner who was HIV-negative, while 25% of YMSM without HIV reported CAI with a different HIV status.

Analyses suggest that among YMSM with HIV, those with problematic substance use are more likely to report CAI or CAI with someone of a different HIV status.

Black YMSM with HIV were less likely to report CAI or CAI with someone of a different HIV status, as were transgender participants. The authors suggest that more research is needed into these subgroups, for whom relatively high rates of infection do not appear to be matched by risky behavior.

YMSM with detectable HIV who told their sex partners about their HIV status were more likely to report CAI compared with YMSM who did not tell their partner about their status.

Employed YMSM with detectable HIV were less likely to report CAI with a partner without HIV than those who were unemployed.

The authors conclude:

"Combination HIV prevention and treatment interventions, which include behavioral, biomedical and structural strategies to increase viral suppression and reduce HIV transmission risk behaviors, that target HIV-infected YMSM are needed. To truly curb HIV incidence among YMSM, we cannot solely rely on one strategy to prevent and treat HIV."

The team points out that the study does not prove a cause, only a link; they also caution that results could be affected by the fact that all the YMSM with HIV who were involved in the study were receiving care.

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

PCPs frequently unaware of PrEP

Dave Muoio, Healio Infectious Disease News | 12.7

Primary care clinicians frequently reported low awareness of pre-exposure prophylaxis, but once informed they often were interested in prescribing the treatment and pursuing education concerning its appropriate use, according to survey data presented at the CDC's National HIV Prevention Conference.

"Though awareness of PrEP among primary care physicians isn't as high as we would like, it's growing — which is promising news," Dawn Smith, MD, MS, MPH, of the division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, CDC, told Infectious Disease News. "But with one-third of providers still unaware, we know that some of their patients who could benefit are still falling through the cracks."

To determine PrEP awareness and support among clinicians, Smith and colleagues conducted surveys of approximately 1,500 physicians and nurse practitioners in 2009, 2010, 2012 and 2013. After determining awareness and knowledge of recommended practices, respondents were provided with data on PrEP indicating a 75% rate of estimated effectiveness. Care providers then were asked to indicate their willingness to prescribe PrEP to at-risk groups, and whether they supported the use of public funding for PrEP treatments.

The researchers reported low clinician awareness during 2009 (24%) and 2010 (29%), although these values increased in 2012 (49%) and 2013 (51%) after clinical trials reported the efficacy of these preventive treatments. Once provided with PrEP information, 92% of clinicians across all surveys reported a willingness to prescribe the treatment to at least one high-risk group. Support for public funding of PrEP ranged from as low as 53% in 2010 to as high as 63% in 2013. Survey data from 2012 and 2013 indicated mixed knowledge on recommended PrEP providing practices, and education topics most often requested by respondents included those concerning PrEP indications (73%), side-effect management (59%), risk-reduction counseling (57%), adherence counseling (53%), sexual history collection (49%) and billing for PrEP-related care (48%).

"We know that PrEP can dramatically reduce the risk for HIV infection. Now we need to ensure that every health care provider knows about PrEP and can counsel their patients at-risk appropriately," Smith said.

Reference:

Smith D, et al. Abstract 1686. Presented at: National HIV Prevention Conference; Dec. 6-9, 2015; Atlanta.

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HIV progress lags for gay, bisexual minorities, Southern states

As reported by Healio Infectious Disease News | 12.7

New cases of HIV infection in the United States dropped 19% from 2005 to 2014 due to continuing declines among several populations, according to data presented at the CDC's National HIV Prevention Conference. However, the data suggested that gay and bisexual minorities and people residing in the South are disproportionately affected by HIV.

According to the CDC, 1.2 million people in the U.S. have HIV, and 40,000 new infections are diagnosed each year.

HIV trends vary by race, ethnicity

While new infections in white gay and bisexual men decreased by 18%, diagnoses among Hispanic gay and bisexual men steadily increased up to 24% even though HIV testing remained stable in recent years (2010-2014). In addition, new diagnoses increased by 22% in black gay and bisexual men before leveling off in 2010. Further increases were observed in younger black gay and bisexual men aged 13 to 24 years, with an 87% increase between 2005 and 2014. The trend, however, showed a 2% decline since 2010, according to the data.

“Although we are encouraged by the recent slowing of the epidemic among black gay and bisexual men — especially young men — they continue to face a disproportionately high HIV burden and we must address it,” Jonathan Mermin, MD, director of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, said in a press release. “Much more must be done to reduce new infections and to reverse the increases among Latino men. There is hope that the National HIV/AIDS Strategy and other efforts are beginning to pay off, but we can’t rest until we see equal gains for all races and risk groups.”

The overall trend of HIV diagnoses in gay and bisexual men increased nearly 6% from 2005 to 2014. Meanwhile, declining trends were observed in heterosexuals (35% decrease) and injection drug users (63% decrease). The steepest decline was among black women who showed a 42% decrease between 2005 and 2014 with continuing declines in more recent years (25% between 2010 and 2014). Despite this trend, black women continue to be disproportionately affected by HIV and accounted for 60% of diagnoses among women in 2014, according to a press release.

Additional data presented by Eugene McCray, MD, director of the CDC’s Division of HIV/AIDS Prevention, showed rates of HIV testing were stable or increased in populations with reduced HIV diagnoses.

“The recent 5-year trends coincide with the launch of the first National HIV/AIDS Strategy and — now that the investment in high-impact prevention approaches has increased — offer promise for further progress,” McCray said in the release. “We have the tools to stop HIV right now. We urgently need to accelerate access to testing, treatment, and new biomedical prevention strategies so that everyone can protect themselves and their partners.”

Gaps in treatment, testing in South

Findings from a 2012 state-by-state analysis also presented during the plenary speech indicated that HIV-related deaths were three times greater in some Southern states compared with other parts of the country.

The national death rate was 19.2 deaths per 1,000 people with HIV and ranged from 7.9 deaths per 1,000 people in Vermont to 30.8 deaths per 1,000 people in Louisiana. Of the 10 states that did not meet the national goal of reducing death rates among patients with HIV to 21.7 per 1,000 people by this year, seven were located in the South.

“It is unacceptable that people with HIV living in many Southern states are more likely to die than those living in other parts of the country,” Mermin said in the release. “Some states are making great strides toward getting people with HIV diagnosed and into care, but every state must do this if we are to reach our national goals for prevention and care.”

People from Southern states also were less likely to know their HIV status. Seventy-seven percent of people in Louisiana were aware of their HIV status vs. 93% of people in New York and Hawaii, according to the data. Overall, 87% of Americans knew their status in 2012.

Along with Hawaii and New York, data indicated that Colorado, Connecticut, and Delaware reached the national goal to increase awareness of HIV status in 90% of people living with HIV. Most (70%) of the lowest percentages were in Southern states, which suggests people in the South were less likely to receive medical care and protect their partners against infection.

McCray said the CDC is responding to this situation by expanding HIV testing in the South, improving access to care and increasing awareness of prevention tools such as condoms, pre-exposure prophylaxis and interventions aimed to reduce risky behavior.

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

Grindr Convinced Me to Take an HIV Test

Joseph Jaafari, VICE Motherboard | 12.1

I slept with a number of men over the last seven years—including some I maybe shouldn’t have. But I’d never had an HIV test.

As a gay man who grew up during the tail end of the AIDS epidemic in the 90s, it was clear to me what my death sentence would be: I was doomed to go the way of Freddy Mercury, Keith Haring, or Pedro Zamora from *The Real World*. But despite all the targeted advertising for people just like me—young and sexually reckless—I would only test for the ones I knew I could cure, like gonorrhea or chlamydia.

So when I logged onto Grindr, a mobile sex app, last week and was shown an ad that offered free at-home HIV tests, I hesitantly opted in.

Three days later, the package showed up on my stoop in Brooklyn. I opened the box, swabbed my gums and waited 20 minutes for my results.

The situation made me wonder: if I hadn’t been using Grindr, how long would it have taken me to get tested? \$40 tests have been available at most pharmacies for three years. Would I have eventually taken the leap myself?

Unfortunately, probably not.

Tech companies like Grindr are starting to play a big role in spreading awareness of HIV, AIDS and, especially, preventative treatments.

The drug Truvada, marketed as the treatment protocol pre-exposure prophylaxis, or PrEP, reduces the risk of contracting HIV by nearly 100 percent, according to a recent study published in the medical journal *The Lancet*.

However, there is a high percentage of men that both don't know enough about the drug or even how to get it, according to a new study conducted by Grindr that was released exclusively to Motherboard.

Truvada, a combination of two antiretroviral drugs, has been used for nearly two decades to treat those with HIV. In 2012, the US Food and Drug Administration approved the drug for prevention and the number of prescriptions has exponentially increased since then.

"Some people call it a miracle drug," said William Nazareth, director of creative media at New York City's Callen-Lorde Community Health Center, an LGBT-focused facility located in Manhattan. The city has some of the highest number of users on gay apps like Grindr and Scruff next to Los Angeles and Chicago, according to the companies.

Nazareth told me the drug isn't for everybody, however. Those on Truvada have to be religious about taking the pill daily and meeting with doctors every three months to be sure there are no liver or kidney problems due to side effects.

Although the side effects aren't common, they have some in the gay community opting to not take the drug. The survey conducted by Grindr, done with the help of the Centers for Disease Control and the San Francisco AIDS Foundation, showed the majority of gay men might be also avoiding Truvada for other reasons.

Of the 4,600 American respondents on the survey, three-quarters weren't on the medication, and more than 37 percent of gay men said they didn't know enough about the drug or even what the drug was. A quarter of those who took the survey were on Truvada.

"Even though our members are using PrEP at a higher level than the overall gay population, I still feel that it's too low," Joel Simkhai, founder and chief executive officer of Grindr, told me over the phone. "PrEP has proven to be very, very effective and it makes sense to take it, and we want to know why more gay men aren't."

Grindr's study also found that one out of 10 men have issues getting access to the drug from their doctor. That number doubled for men of color.

That's not surprising, Nazareth told me.

"We hear our patients have a hard time getting PrEP from their provider, and they say it's based on moral grounds... but there are also cases where doctors don't want to give out Truvada because they say 'I'm not a doctor that specializes in HIV and this is an HIV drug,'" Nazareth said. "But when we think about society as a whole, I think a huge issue around PrEP is that people are worried gay men are going to have a lot of sex without condoms—regardless of how often heterosexuals are having sex without condoms."

Nazareth introduced me to Cres Hernandez, a 33-year-old waiter who lives in Astoria, Queens and is also on Truvada. Prior to when he got his prescription from Callen-Lorde, the LGBT-focused Manhattan clinic,

Hernandez said his former doctor asked about his sexual history during a routine HIV test but said the doctor's questions turned to judgement.

"It was so humiliating to me, because here I am so afraid and vulnerable and bearing my soul to this stranger and even though the results wound up being negative, what I took away from experience was how judged and shamed I felt by a professional," Hernandez told me.

On the flip, Hernandez said he used to be hesitant about, if not downright opposed to, having sex with those who had HIV. For him, Truvada took away that fear.

Hernandez's openness toward sleeping with an HIV positive person made me reach out to founder of the gay hookup app Scruff, Jason Marchant. Marchant has been a large proponent of Truvada, and in a number of interviews he's been open about how the drug has helped him overcome his fear of having sex with another HIV-positive man.

"After a long personal journey with HIV-phobia and anxiety about safe sex, going on Truvada for PrEP turned into a real turning point in how I looked at sex and how I viewed people who were HIV positive," Marchant said. Scruff is now the only gay app that gives users the option show on their profile if they are on Truvada, which prompted a pat on the back for the company from the Aids Healthcare Foundation.

Other tech companies have taken notice, including Grindr. The company plans to use the results from its survey to begin educating users about Truvada.

"We have this opportunity to speak to our users, and we can do this and we should be doing this. And it is effective," said Grindr's Simkhai, adding the average Grindr user spends close to an hour on the app every day. "Our guys are on the app all the time. We are probably one of their most-engaged mediums that they pay attention to. So why not promote sexually transmitted infection prevention?"

There are public health researchers, such as UCLA professor of medicine and public health Dr. Jeffrey Klausner, who have found hook-up apps are not ideal platforms to spread awareness on HIV prevention.

"We see that when people go to sex clubs or bars, their primary purpose is not to receive information. But with that said, that's where the high-risk individuals are and we need to meet them with our interventions," Klausner told me.

Klausner also happened to be in charge of the program that gave out 400 free self-test kits through a Grindr ad—the same one I had clicked on to get my test.

It's odd to think before last week, had I not been so anxious to hook up on to Grindr, I wouldn't have been sitting in my bathroom staring at a paper strip waiting to see if I was HIV positive. The test came back negative, but the experience made me more tangibly aware of the risks. And that's making us all a little bit safer.

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Scientific Papers/Conference Abstracts

On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection

Molina JM, Capitant C, Spire B, et al. *NEJM* 2015;373:2237-2246

Background

Antiretroviral preexposure prophylaxis has been shown to reduce the risk of human immunodeficiency virus type 1 (HIV-1) infection in some studies, but conflicting results have been reported among studies, probably due to challenges of adherence to a daily regimen.

Methods

We conducted a double-blind, randomized trial of antiretroviral therapy for preexposure HIV-1 prophylaxis among men who have unprotected anal sex with men. Participants were randomly assigned to take a combination of tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC) or placebo before and after sexual activity. All participants received risk-reduction counseling and condoms and were regularly tested for HIV-1 and HIV-2 and other sexually transmitted infections.

Results

Of the 414 participants who underwent randomization, 400 who did not have HIV infection were enrolled (199 in the TDF-FTC group and 201 in the placebo group). All participants were followed for a median of 9.3 months (interquartile range, 4.9 to 20.6). A total of 16 HIV-1 infections occurred during follow-up, 2 in the TDF-FTC group (incidence, 0.91 per 100 person-years) and 14 in the placebo group (incidence, 6.60 per 100 person-years), a relative reduction in the TDF-FTC group of 86% (95% confidence interval, 40 to 98; $P=0.002$). Participants took a median of 15 pills of TDF-FTC or placebo per month ($P=0.57$). The rates of serious adverse events were similar in the two study groups. In the TDF-FTC group, as compared with the placebo group, there were higher rates of gastrointestinal adverse events (14% vs. 5%, $P=0.002$) and renal adverse events (18% vs. 10%, $P=0.03$).

Conclusions

The use of TDF-FTC before and after sexual activity provided protection against HIV-1 infection in men who have sex with men. The treatment was associated with increased rates of gastrointestinal and renal adverse events. (Funded by the National Agency of Research on AIDS and Viral Hepatitis [ANRS] and others; ClinicalTrials.gov number, NCT01473472.)

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

HIV-1 virological remission lasting more than 12 years after interruption of early antiretroviral therapy in a perinatally infected teenager enrolled in the French ANRS EPF-CO10 paediatric cohort: a case report

Frangé P, Faye A, Avettand-Fenoel V, et al. *Lancet HIV* 2015; [Epub ahead of print]

Background:

Durable HIV-1 remission after interruption of combined antiretroviral therapy (ART) has been reported in some adults who started treatment during primary infection; however, whether long-term remission in vertically infected children is possible was unknown. We report a case of a young adult perinatally infected with HIV-1 with viral remission despite long-term treatment interruption.

Methods:

The patient was identified in the ANRS EPF-CO10 paediatric cohort among 100 children infected with HIV perinatally who started ART before 6 months of age. HIV RNA viral load and CD4 cell counts were monitored from birth. Ultrasensitive HIV RNA, peripheral blood mononuclear cell (PBMC)-associated HIV DNA, HIV-specific T-cell responses (ie, production of cytokines and capacity to suppress HIV infection), reactivation of the CD4 cell reservoir (measured by p24 ELISA and HIV RNA in supernatants upon phytohaemagglutinin activation of purified CD4 cells), and plasma concentrations of antiretroviral drugs were assessed after 10 years of documented control off therapy.

Findings:

The infant was born in 1996 to a woman with uncontrolled HIV-1 viraemia and received zidovudine-based prophylaxis for 6 weeks. HIV RNA and DNA were not detected 3 days and 14 days after birth. HIV DNA was detected at 4 weeks of age. HIV RNA reached 2.17×10^6 copies per mL at 3 months of age and ART was started. HIV RNA was undetectable 1 month later. ART was discontinued by the family at some point between 5.8 and 6.8 years of age. HIV RNA was undetectable at 6.8 years of age and ART was not resumed. HIV RNA has remained below 50 copies per mL and CD4 cell counts stable through to 18.6 years of age. After 11.5 years of control off treatment, HIV RNA was below 4 copies per mL and HIV DNA was 2.2 log₁₀ copies per 10⁶ PBMCs. The HLA genotype showed homozygosity at several loci (A*2301-, B*1503/4101, C*0210/0802, DRB1*1101-, and DQB1*0602-). HIV-specific CD8 T-cell responses and T-cell activation were weak.

Interpretation:

Findings from this case suggest that long-term HIV-1 remission is possible in perinatally infected children who receive treatment early, with characteristics similar to those reported in adult HIV post-treatment controllers. Further studies are needed to understand the mechanisms associated with HIV remission and whether early treatment of infected children might favour the conditions needed to achieve HIV control after treatment discontinuation.

View the paper online: [Abstract](#)

Relationship Dynamics and Sexual Risk Reduction Strategies Among Heterosexual Young Adults: A Qualitative Study of Sexually Transmitted Infection Clinic Attendees at an Urban Chicago Health Center

Hotton AL, French AL, Hosek SG, et al. *AIDS Patient Care and STDs* 2015;29(12):669-674

Abstract:

Few studies have examined risk-reduction alternatives to consistent condom use for HIV prevention among heterosexual young adults. We used qualitative methodology to explore risk reduction strategies and contextual factors influencing attempts to reduce risk in an urban, high morbidity sexually transmitted infection (STI) clinic. Focus groups were conducted October–December 2014 with heterosexually identified men (n = 13) and women (n = 20) aged 18–29 seeking STI screening at an urban clinic. Groups were audio recorded, transcribed verbatim, and analyzed for thematic content using Atlas.ti software. Quantitative information included sociodemographics, HIV/STI testing history, and 6-month sexual behaviors. Among 33 predominantly African-American participants with a median age of 22, risk-reduction strategies included monogamy agreements, selective condom use with casual and high-risk partners, and frequent HIV/STI testing, though testing was commonly used as a post-hoc

reassurance after risk exposure. Many men and women used implicit risk assessment strategies due to mistrust or difficulty communicating. Concurrency was common but rarely discussed within partnerships. Despite attempts to reduce risk, monogamy agreements were often poorly adhered to and not openly discussed. Alcohol and substance use frequently interfered with safer sexual decisions. Participants were aware of HIV/STI risk and commonly practiced risk-reduction strategies, but acknowledged faulty assumptions and poor adherence. This work provides insights into risk-reduction approaches that are already used and may be strengthened as part of effective HIV/STI prevention interventions.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

Watch and Find: Webinars and HIV

Blog.aids.gov

When was the last time you watched a webinar? Virtual participation can help you to stay abreast of what's happening in the world of HIV prevention, care and treatment or research.

Watch

We recently redesigned the [AIDS.gov webinars resource page](#) to better share information about webinars that we think might be useful to YOU.

The following National Institute of Health (NIH) webcast is just one of the resources we have listed – and we think it's particularly worth watching:

Ambassador-at-Large Dr. Deborah L. Birx will deliver [the 2015 Joseph J. Kinyoun Memorial Lecture Tuesday, December 15](#) from 3:00 to 4:00 pm. She will discuss how data are being leveraged to save lives and drive progress toward sustained control of the global HIV/AIDS pandemic. Birx is the U.S. Global AIDS Coordinator and U.S. Special Representative for Global Health Diplomacy. She oversees implementation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the largest commitment to combat a single disease by any nation in history. PEPFAR collects and analyzes data to understand health care service cost, quality and achievements at community care sites around the globe. Birx will describe how use of these detailed data has been critical for understanding local HIV prevalence, determining the quality and cost of services and defining key gaps. She will discuss how PEPFAR is working with host countries to use these data to refocus programs for maximal impact. No registration is needed to watch this one. Just [visit this NIH page on December 15](#).

Find

Visit [our webinars page](#) for upcoming sessions and to find sessions you may missed. Our page includes a short list of practical tips for webinar organizers and [a brief introduction to using webinars and webcasts](#).

Funding Opportunity – HIV and Hepatitis Social Marketing Campaign subcontractors

Greetings!

The Office of Minority Health Resource Center (OMHRC) has released an announcement for HIV and Hepatitis Social Marketing Campaign subcontractors. They are looking to provide up to 12 awards to community organizations to conduct HIV and Hepatitis social marketing campaigns.

Applications are due on Monday, January 11, 2016

[Click here](#) to download the application.

Additional information can be found on the website:

<http://www.minorityhealth.hhs.gov/omh/content.aspx?ID=10292&lvIID=16>

The project will provide subcontractors to CBOs and FBOs to improve coordination between health providers, increase the number of community partnerships in addressing HIV and hepatitis, increase health materials available among minority populations and increase the collaboration efforts and information sharing between minority agencies and organizations within the US. Each social marketing campaign must target only one of the following populations, or a subgroup of a population which includes immigrants and refugees: African Americans, Asian Americans, Hispanics/Latinos, American Indians/Alaska Natives, or Native Hawaiians and Pacific Islanders.

Please share this opportunity with all of your California colleagues and interested friends.

For more information: [Click here](#)

Job/Internship Postings

Director of Programs and Partnerships - NCSD

Organization: National Coalition of STD Directors (NCSD)

The National Coalition of STD Directors (NCSD) is hiring an exciting senior level position -- the Director of Programs and Partnerships.

The Director of Programs and Partnerships oversees a significant portfolio of work as Team Lead for the Technical Assistance and Health Equity Promotion (TAHEP) area of work. The TAHEP team responds to and empowers the work of NCSD's member health departments and other partners to prevent STDs and other adverse sexual health outcomes among disproportionately impacted populations to include adolescents, gay men and other men who have sex with men, and people of color. The Director is involved in day-to-day management of staff and projects undertaking multi-faceted initiatives in sexual health and STD prevention, and also is directly involved in delivering high quality trainings and presentations. The position is charged with developing and maintaining key partnerships to advance

STD prevention and NCSD priorities and is expected to monitor budgets and assist the Executive Director in development to support TAHEP initiatives. This position is based in NCSD's Washington, D.C. office and reports directly to the Executive Director. The Director of Programs and Partnerships is a member of NCSD's Senior Team. The position has four direct reports.

NCSD is an equal-opportunity employer dedicated to a diverse workforce.

[The full job description can be found here.](#)

To apply, please send a cover letter, resume, short writing sample, and three professional references to lmathias@ncsddc.org. Position will be open until filled. No phone calls please.

Distance Learning Specialist – SF DPH

Organization: San Francisco Department of Public Health
Location: San Francisco, CA
Salary: \$32.36 - \$39.34/hour
App. Deadline: 12/18/15

The Department of Public Health is accepting applications for one (1) permanent exempt full-time position in Class 2589 Health Program Coordinator I within the Center for Learning and Innovation (CLI). CLI is a branch within the Population Health Division that is dedicated to fostering a culture of learning, trust, and innovation. It organizes several programs focused on 1) internal training and workforce development; 2) recruitment of the future public health workforce through meaningful internships; 3) catalyzing innovations in public health through human centered design principles; and 4) capacity building for external public health agencies and related stakeholders.

Under the direction of the CLI Manager for Capacity Building Initiatives, this position will play a key role in Project PrIDE, a project funded by the Centers for Disease Control and Prevention to increase the uptake of HIV pre-exposure prophylaxis (PrEP) among men who have sex with men (MSM) of color and transgender persons at risk for infection.

The Distance Learning Specialist will work with the CBA Manager and others at CLI to develop and implement Distance Learning strategies. The Specialist's primary responsibilities are creating training materials including manuals, power point presentations, eLearning modules, and other teaching media. The Specialist will work closely with subject matter experts to convene learning communities in person and online using web-based videoconferencing software. The Specialist also will be responsible for maintaining a SharePoint repository of online learning resources (e.g., videos, toolkits, lectures) as well as CLI's Learning Management System to encourage online learning and exchange between staff from health departments and community partners. Finally, this position will collaborate with the overall grant team to assist with evaluation, reporting efforts, coordination of messages, and the highest standards for interactive learning.

The duration of this Permanent Exempt, Category 18 position is three (3) years.

LOCATION: 25 Van Ness Ave, San Francisco
SHIFT: 8:00am – 4:30pm Monday-Friday

This position performs the following essential duties:

- Engages internal and external staff and partners to identify knowledge, skill and abilities for successful delivery of PrEP.
- Leverages information gained through formal and informal needs assessments to recommend, design, develop and implement the appropriate learning solutions for the target audiences which may include online learning, instructor-led training, virtual training, instructional videos, audio/video scripts and role play exercises.
- Collaborates with subject matter experts to develop and review the training content and proactively identify additional experts who can address content gaps.
- Develops knowledge assessments and programs to measure student learning and application.
- Measures and assesses the effectiveness of in-person and on-line learning communities and training solutions to inform future program requirements and identify areas where additional learning and reinforcement are required.
- Actively reviews and evaluates the in-person and on-line training solutions library to determine when content needs to be updated, replaced, or retired.
- Builds and sustains participant-centered Learning Communities in cooperation with grant project staff and staff from CLI.
- Provides logistical support for the development and implementation of learning communities.
- Handles day-to-day operations, such as scheduling of events, for learning communities.
- Participates in assessment activities and collects and prepares data for internal, state and grant reports.

The Health Program Coordinator I (Distance Learning Specialist) also performs other related duties as assigned.

Minimum Qualifications

1. Possession of a baccalaureate degree from an accredited college or university; **AND**
2. One (1) year of verifiable administrative or management experience with primary responsibility for overseeing, monitoring, or coordinating a program providing health and/or human services.

Substitution: Additional experience as described above may substitute for the required degree on a year-for-year basis (up to a maximum of 4 years). Thirty (30) semester units or forty-five (45) quarter units equal one year. One (1) year of experience is equivalent to 2,000 hours.

DESIRED QUALIFICATIONS:

- Possession of a baccalaureate degree with major in health education or a related communications field.
- 3 - 4 years of health education curriculum development experience or instructional design (a Master's degree in a health education-related field can substitute for up to 2 years of experience).
- Experience managing, developing, and delivering health education content, including working with subject matter experts.
- Experience in the area of high impact HIV prevention, including PrEP.
- Proficiency creating eLearning courses using authoring software such as Articulate.
- Excellent data visualization skills and creation of compelling infographics.
- Proficiency with Microsoft Word, PowerPoint, SharePoint, webinar software (e.g., GoToMeeting), and videoconferencing software (e.g., Zoom).

- Experience working on HIV and/or public health issues with diverse racial/ethnic communities, particularly communities of color as well as gay/lesbian/bisexual/transgender communities.
- Experience liaising with contractors and vendors and managing budgets.
- Experience with grant preparation and reporting, including NIH and CDC grants.

How To Apply

Applications for City and County of San Francisco jobs are being accepted through an online process. Visit www.jobaps.com/sf to register an account (if you have not already done so) and begin the application process.

- Select the desired job announcement
- Select “Apply” and read and acknowledge the information
- Select either “I am a New User” if you have not previously registered, or “I have Registered Previously”
- Follow instructions on the screen

Computers are available for the public (from 8:00am to 5:00pm Monday through Friday) to file online applications in the lobby of the Department of Human resources at 1 South Van Ness Avenue, 4th Floor, San Francisco.

You can also watch this video for further assistance with our online application system:

<http://www.youtube.com/watch?v=4-kUFHXhBjQ&feature=youtu>

Applicants may be contacted by email about this announcement and, therefore, it is their responsibility to ensure that their registered email address is accurate and kept up-to-date. Also, applicants must ensure that email from CCSF is not blocked on their computer by a spam filter. To prevent blocking, applicants should set up their email to accept CCSF mail from the following addresses (@sfgov.org, @sfdpw.org, @sfport.com, @flysfo.com, @sfwater.org, @sfdph.org, @asianart.org, @sfmta.com, @sfpl.org).

Applicants will receive a confirmation email that their online application has been received in response to every announcement for which they file. Applicants should retain this confirmation email for their records. Failure to receive this email means that the online application was not submitted or received. All work experience, education, training and other information substantiating how you meet the minimum qualifications, if requested, must be included on your application by the filing deadline. Information submitted after the filing deadline will not be considered in determining whether you meet the minimum qualifications.

Applications completed improperly may be cause for ineligibility, disqualification or may lead to lower scores.

Resumes may be attached to the application, however resumes will not be accepted in lieu of a complete City and County of San Francisco application.

If you have any questions regarding the application process, please contact the exam analyst, Katelynn Luong, at (415) 554-2920 or email: Katelynn.Luong@sfdph.org.

For questions regarding the vacancies, please contact the hiring manager, Gary Najarian, at (415) 437-6226 or email: Gary.Najarian@sfdph.org.

Verification (proof) of Education:

Applicants may be required to provide a copy of a diploma or official transcript to verify qualifying education at any time in the application, examination and/or departmental selection process, to show that minimum qualifications have been met.

Applicants who have obtained education from a foreign college or university must provide a Foreign Transcript Evaluation letter from a National Association of Credentials Evaluation Service (NACES) approved agency. A list of approved agencies can be found at: <http://www.naces.org>

Verification (proof) of Experience:

Applicants may be required to submit verification of qualifying education and experience at any point in the application, examination and/or departmental selection process. If verification is required, failure to provide it may result in disqualification from the selection process.

Verification of qualifying experience must be signed by the employer's authorized representative on the employer's letterhead, and specify the name of the applicant, dates of employment, job title(s), dates of service and duties performed. City and County of San Francisco employees will receive credit for the duties of the class to which the employee was appointed. City and County of San Francisco employees do not need to submit verification of their City employment, but must submit verification of outside experience. City employment will be verified by the employee's record. City and County of San Francisco employees will not receive credit for experience obtained outside of their classification unless recorded in accordance with the provisions of the Civil Service Rule 110.9.1. For more information, please visit: <http://www.sfdhr.org/index.aspx?page=20#verification>.

NOTE: Falsifying one's education, training, or work experience or attempted deception on the application may result in disqualification for this and future job opportunities with the City and County of San Francisco.

For more information and to apply: [Click here](#)

Aaron Kavanaugh

Office of Policy, Planning, and Communications
STD Control Branch, California Department of Public Health
850 Marina Bay Parkway, Building P, 2nd Floor
Richmond, CA 94804

Tel: 510-620-3402

Fax: 510-620-3180

Web: std.ca.gov

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