

[STD Update] FYI 2-24: CalOSHA warns condom use required in adult films, President Obama cuts funding for all abstinence-only sex education, Vaginal ring provides partial protection from HIV, 4 papers, 4 jobs, more.

California Stories

Cal/OSHA Warns Condom Use Required in Adult Films

*Actors in P*rnographic Films Fight Proposal to Enforce Safety Regulations*

National Stories

President Obama cuts funding for all abstinence-only sex education

Moderate alcohol consumption may be more harmful to people with HIV

"Biomed-matching" Emerges among Gay Men Who Say to Partners, "I'm also on PrEP"

PrEP use rising among high-risk gay men in Washington State

Vaginal Ring Provides Partial Protection from HIV in Large Multinational Trial

Major disparities persist in lifetime risk of HIV diagnosis in the US

Scientific Papers/Conference Abstracts

Privacy and Confidentiality Practices In Adolescent Family Planning Care At Federally Qualified Health Centers

Providing ART to HIV Seropositive Persons Who Use Drugs: Progress in New York City, Prospects for "Ending the Epidemic"

A Comparison of Men Who Have Sex with Men, People Who Inject Drugs and High-Risk Heterosexuals' Risk for HIV Infection, San Francisco

Hypersexual, Sexually Compulsive, or Just Highly Sexually Active? Investigating Three Distinct Groups of Gay and Bisexual Men and Their Profiles of HIV-Related Sexual Risk

Resources, Webinars, & Announcements

New edition of HIV & sex booklet

Pre-conference registration is now open

New & Updated STD Resources from CDC

Job/Internship Postings

Clinical Regional Coordinator – CAPTC

Health Program Coordinator III (Project PrIDE Coordinator) - SFDPH

Epidemiologist / Medical Epidemiologist- NCHHSTP/DSTDP

Epidemiologist - NCHHSTP/DSTDP

California Stories

Cal/OSHA Warns Condom Use Required in Adult Films

Standards Board Vote Does Not Change Current Requirements

News Release, State of California Department of Industrial Relations | 2.19

Following Thursday's meeting of the California Occupational Safety and Health Standards Board where it did not adopt a proposed standard pertaining to the adult film industry, Cal/OSHA warns that barrier protection including condoms is still required to protect adult film workers from exposure to blood or other potentially infectious materials. The existing standard has been in effect since 1993 and is enforced by Cal/OSHA.

"Condoms are required to protect adult film workers from exposure to HIV and other sexually transmitted infections," said Cal/OSHA Chief Juliann Sum. "Cal/OSHA will continue to enforce the existing regulations and investigate complaints in the adult film industry."

Workers in the adult film industry should know current laws protect them from injury and illness on the job, and where to go for help if their employer doesn't follow those laws. More information on how to file a complaint with Cal/OSHA can be found on the Cal/OSHA website or by calling (714) 558-4300. Employers in the adult film industry must also know how to protect their employees from health and safety hazards and understand the consequences of failing to comply with state regulations.

Cal/OSHA helps protect workers from health and safety hazards on the job in almost every workplace in California. Cal/OSHA's Consultation Services Branch provides free and voluntary assistance to employers and employee organizations to improve their health and safety programs. Employers should call (800) 963-9424 for assistance from Cal/OSHA Consultation Services.

Employees with work-related questions or complaints may contact DIR's Call Center in English or Spanish at 844-LABOR-DIR (844-522-6734). The California Workers' Information line at 866-924-9757 provides recorded information in English and Spanish on a variety of work-related topics. Complaints can also be filed confidentially with Cal/OSHA district offices.

Members of the press may contact Julia Bernstein or Peter Melton at (510) 286-1161, and are encouraged to subscribe to get email alerts on DIR's press releases or other departmental updates.

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

Actors in P*rnographic Films Fight Proposal to Enforce Safety Regulations

Thomas Fuller, The New York Times | 2.18

The California p*rnographic film industry turned out in force Thursday to oppose regulations that would have forced actors to wear condoms and, in some cases, goggles, face shields or rubber gloves when on camera.

A parade of actors — fully dressed, and some colorfully so — took to the podium in a government auditorium here as five members of the California Occupational Safety and Health Standards Board listened to their pleas for more than five hours.

“If you guys don’t want us here, we can take our business outside of California,” Jessy Dubai, an actress wearing a form-fitting beige dress, told the board, echoing a common threat in the long-running dispute over condoms that the lucrative business will decamp for Nevada and elsewhere if this state cracks down.

After Ms. Dubai finished her comments, she sashayed past the board in stiletto heels. The hearing ended with the board deciding to vote down the proposal as written, but to reconsider a revised version over the next year.

There were three votes in favor of the more stringent guidelines and two votes against them; the panel, which was down two members, requires four votes in favor to pass a measure.

One board member said he wanted to see “more flexibility” in the regulations, and others sought clarifications on whether spouses filming together would need to wear condoms.

P*rnographic film actors, producers and directors at Thursday’s meeting argued that voluntary regulations adopted by the industry that require regular testing for sexually transmitted diseases were adequate to protect actors.

“This is a malicious persecution of this industry,” said Brad Armstrong, a performer for more than two decades. “Other industries go unchecked with the same risk factors and the same contaminants.”

Mr. Armstrong, dressed in a three-piece suit, held up photographs of bloodied mixed martial art fighters and plumbers, two occupations in which he said there could be continual exposure to dangerous bacteria.

The proposed rules, he said, were “not only impossible to implement, they are impossible to enforce.”

In the prosaic language of a workplace safety, the new standards, which run 21 pages, call for a host of protections ranging from the use of condoms (which the regulations describe as “personal protective equipment”) to ensuring that “contaminated laundry is handled as little as possible, and is bagged at the site of usage.”

Sex toys and “other objects” must be cleaned and disinfected and “eye protection” must be used if there is a risk that bodily fluids reach the face.

The regulations mandate that “soaps and other cleaners are not irritating” and that “nonlatex condoms, shall be readily accessible to those employees who are allergic to the equipment normally provided.”

The case stems from a petition filed in 2009 by a charitable organization, the AIDS Healthcare Foundation, which called for greater protections for the industry. Members of the organization attended Thursday’s meeting but were far outnumbered by the actors.

Adam Carl Cohen, a public health consultant with the foundation, said he was disappointed with the decision.

“I think it’s a sad day for public health,” he said. “Every major medical and public health organization has stated that condoms should be required on all adult film sets.”

Mr. Cohen said the campaign for greater regulation of the p*rnographic film industry was far from over. In addition to the proposal for workplace regulations that will be reviewed over the next year, voters in November will vote on a separate piece of legislation, the California Safer Sex in the Adult Film Industry Act.

Federal and California law mandate that employees be protected from potentially infectious bodily fluids.

California regulators argue that these laws require the use of condoms and other protection and that the proposed regulations clarify those rules for employees in the p*rnographic film industry.

“You are already required to wear condoms; you’re just not doing it,” Dave Thomas, the chairman of the work safety board, said Thursday. “That’s the law. It’s just not being enforced.”

The actors argued that wearing goggles or other types of face protection would make their films unsellable. They also said the regulations would force their business underground, where fewer regulations would be observed.

That point seemed to resonate with at least two of the five board members present.

“I’m actually more torn over this than I can ever explain,” said David Harrison, a board member.

“I see what I do as my art,” said Lily Cade, an actress who took the podium. “And in the past, throughout history, art has been persecuted.”

The actors were expansive on their love for their profession, and some were almost in tears. Some made the point that the loss of the adult film industry to places like Las Vegas, where some production has already moved, would drain California of tax revenue.

“P*rn is a billion-dollar industry,” said Savannah Fox, who wore a black jacket and orange-tinted hair. “It’s not going to stop.”

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

National Stories

President Obama cuts funding for all abstinence-only sex education

WITW Staff, New York Times Live | 2.18

In his proposed federal budget for 2017, President Obama has removed all funding for abstinence-only education, by cutting a \$10 million per year grant from the Department of Health and Human Services that supports such programs, which have never been proven effective. A 2007 study by prominent

sexual health researcher Douglas Kirby, which looked at the effect of sex ed on teen pregnancies and sexually transmitted diseases concluded that “there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners.” Despite the lack of scientific evidence, over the last 25 years Congress has spent nearly \$2 billion on such “abstinence-until-marriage” programs. The Sexuality Information and Education Council of the United States (SIECUS) praised President Obama for his administration’s commitment “to secure the right to quality sexuality education for young people,” which also entails a proposed \$4 million increase for the Teen Pregnancy Prevention Program.

Read the full story at [Teen Vogue](#).

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

Moderate alcohol consumption may be more harmful to people with HIV

Keith Alcorn, [aidsmap.com](#) | 2.10

Safe drinking limits for people living with HIV may be lower than the recommendations for the rest of the population, a large US cohort study suggests, especially in people not taking antiretroviral therapy. The findings are published by the journal *Drug and Alcohol Dependence*.

The study findings indicate that only one country – the United Kingdom – is currently recommending a level of alcohol consumption for the general population that would also minimise the harm of alcohol consumption for people living with HIV. All other national drinking limits for safer consumption would still place people with HIV at increased risk of alcohol-related harm compared with counterparts without HIV, the study shows. The study found that drinking more than 14 units a week – about one drink a day in US terms – increased the risk of death for men with HIV. The increased risk of death only became evident for men without HIV at higher levels of alcohol consumption.

Safe drinking advice now varies widely from country to country. Recently issued United Kingdom guidance recommends no more than 14 units a week for men and women, compared to the equivalent of 24 units a week for men in the United States (14 drinks per week) and 35 units a week in Spain. US guidance recommends women to restrict alcohol intake to 12 units a week, whereas Spanish guidance recommends no more than 21 units a week for women.

High alcohol consumption raises the risk of developing a wide range of cancers, particularly breast cancer in women, and bowel cancer, oesophageal cancer and cancers of the mouth and throat in both sexes.

The risk of cancers in the mouth, throat and oesophagus (gullet) is further raised by smoking in people who drink alcohol. Alcohol also increases the absolute risk of liver cancer.

High alcohol consumption also increases the risk of stroke and cardiovascular disease, in particular by raising blood pressure. There is considerable debate as to whether drinking a small amount of alcohol protects against heart disease.

United Kingdom drinking advice has been calculated so that for a person who drinks 14 units or less each week, the risk of dying of an alcohol-related condition is one in a hundred. In a briefing for

journalists issued by the Science Media Centre last month, Professor Matt Field of Liverpool University's UK Centre for Tobacco and Alcohol Studies set out the absolute risk of some cancers at higher levels of alcohol consumption: "Among men, approximately 8 in 1000 non-drinkers or drinkers who stick to the weekly limit (no more than 14 units per week) are at risk of developing liver cancer, but this rate rises to 11 in 1000 for men who drink between 14 and 35 units per week. But for cancer of the oesophagus, the rates are increased for men who drink even within the weekly guideline (13 in 1000) compared to those who abstain completely (6 in 1000), and further increased for those who exceed the guideline (25 per 1000 in men who drink between 14 and 35 units per week)."

The Veterans Aging Cohort Study

The US study was designed to test whether alcohol consumption is associated with a greater degree of harm in the HIV-positive population compared to an uninfected population with similar characteristics. The study population consisted of military veterans receiving care through Veterans Health Administration health care facilities in the United States who had been enrolled into the Veterans Aging Cohort Study (VACS). The study comprised 18,145 people with HIV and 42,228 uninfected individuals who had reported any alcohol consumption when asked a series of questions about alcohol use as part of routine medical follow-up. The study excluded women, who make up only 3% of the VACS population, therefore making it difficult to draw any reliable conclusions from findings in women.

The researchers then looked at mortality and "physiologic injury" – laboratory markers which predict physical illness. The latter was calculated using the VACS Index, a well-validated scoring system which predicts hospitalisation and morbidity including fractures. The VACS Index score has been shown to change in response to alterations in alcohol consumption and drug use, and to changes in treatment adherence. The score is calculated using the following measurements: haemoglobin, kidney function, hepatitis C infection, viral load, CD4 count and FIB-4 score calculated with reference to ALT/AST and platelet count.

The median age of study participants was 52.5 years for men living with HIV and 54 years for uninfected men. Thirty-one per cent of those with HIV and 16% of those without HIV had hepatitis C infection. Approximately three-quarters of men with HIV (76%) had an undetectable viral load.

Although the majority of those with HIV who reported alcohol use were light or moderate drinkers, consuming less than 14 US drinks per week (81%), the researchers classified 24% of men with HIV as having an "unhealthy" level of alcohol consumption based on responses to the AUDIT-C questionnaire, which asks about the number of days on which drinking takes place, the quantity drunk and the frequency of heavy drinking (six or more drinks in one day). A male drinker would fall into this category if they reported drinking no more than two to three times a week and drank at least three standard drinks on each occasion, or reported ever consuming six or more drinks on one occasion. Thresholds for unhealthy drinking in the AUDIT-C questionnaire are lower for women and for people aged over 65.

During a median follow-up period of 4.8 years the mortality rate was 2.7 deaths per 100 person-years among men with HIV and 1.8 per 100 person-years among men without HIV. When mortality rates were plotted by alcohol consumption, those men living with HIV with the highest range of consumption, whether measured by total number of drinks (70+ drinks per month), by AUDIT-C score (8-12) or by heavy episodic drinking (daily), had mortality rates almost twice as high as those with the lowest consumption (around 5 deaths per 100 person-years of follow-up). The difference in mortality was far less pronounced for men without HIV infection (approximate 25% increase in mortality).

Mortality at all levels of alcohol consumption was higher for men with HIV than those without, but the difference in mortality rates became greater as alcohol consumption rose.

A similar pattern was evident when the mean VACS Index scores were compared for different levels of alcohol consumption. Use of the VACS Index – which correlates with physiological injury – showed that there was no level of alcohol consumption that was protective in men with HIV whereas drinking between 3 and 29 US standard drinks per month was protective for people without HIV.

Multivariate analysis which adjusted for the effects of race, smoking and hepatitis C showed that men with HIV who drank between 30 and 69 drinks per month had a 30% higher risk of death during the follow-up period than men who drank only 1 or 2 drinks per month (HR 1.30, 95% confidence interval 1.14-1.50). Men with HIV who drank more than 70 drinks per month had a 50% increased risk of death (HR 1.50, 95% CI 1.28-1.76). In comparison, those without HIV had an increased risk of mortality only when they consumed more than 70 drinks per month (HR 1.13, 95% CI 1.00-1.28).

Why might alcohol be more harmful for people with HIV?

The investigators say that people with HIV are probably more vulnerable to the harmful effects of alcohol because they have higher blood alcohol levels for every unit of exposure, an explanation supported by a separate VACS cohort study which showed that people with HIV reported intoxication at lower levels of alcohol consumption, with the effect most pronounced in people with detectable viral load. (McGinnis) The authors of that study suggested that alcohol absorption may be higher in people with untreated HIV infection due to “intestinal barrier dysfunction”, and that body mass index is lower on average in people with HIV. Another study found that blood alcohol levels are higher in untreated HIV infection.

The investigators concluded that “HIV-positive individuals consuming more than 30 drinks per month are at increased risk of all-cause mortality and physiologic frailty. This would translate to a recommended drinking limit ... of no more than 1 drink containing alcohol per day.”

Implications for alcohol advice

Thirty drinks a month may not sound like a lot, but different countries have different ways of calculating alcohol consumption. In the United States one “standard drink” contains 14g of alcohol. In Australia a “standard drink” contain 10g of alcohol. In the United Kingdom one “unit” of alcohol contains 8g of alcohol. In UK units, 70 drinks a month is the equivalent of 30 units a week, while 30 drinks a month – the level at which harm became evident in the US Veterans cohort – is the equivalent of 13 units a week – almost the same as the new limit for safer drinking recommended for the general population by the UK’s Department for Health last month (14 units).

In practical terms, the UK recommends drinking no more than 6 glasses of wine, or six pints of beer, or 14 small measures of spirits, each week, with drinking spread over several days.

How people choose to interpret these findings will depend on their attitude to risk. For some, total abstinence may be the only comfortable way to deal with alcohol-related risk, but others may conclude that the increase in the absolute risk of alcohol-related harm for people with HIV detected in this study is small enough to make little difference to their views on alcohol consumption.

The major limitation of this study is that it looked at alcohol consumption only in men. Further research is needed in a large cohort of women with HIV where reliable information about alcohol consumption has been recorded. Nevertheless, the greater harm caused by a unit of alcohol in women is well established, suggesting that findings for men are highly likely to apply to women, but at lower levels of alcohol consumption.

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

“Biomed-matching” Emerges among Gay Men Who Say to Partners, “I’m also on PrEP”

Emily Newman, BETA | 2.17

Gay men are engaging in even more nuanced decision-making about sex, report Michael Newcomb, PhD and colleagues [in a paper published in *Epidemiology and Prevention*](#). They found that it is common for men to disclose PrEP use or that they have an undetectable viral load on mobile dating apps, and that men use this knowledge to guide decisions they make about how they have sex. While strategies such as seropositioning (risk-reducing sexual positions) and seroadaptation (choosing same-status partners) have been used for years, new prevention strategies including [PrEP](#) and [treatment as prevention](#) (TasP) also play a role in how men talk about HIV and make decisions about the type of sex to have.

In an online survey conducted from November 2014 to February 2015, Newcomb and colleagues surveyed 668 men who find sex partners using mobile dating apps. They asked if study participants had ever had a potential sex partner connected through a mobile app disclose PrEP use or being HIV-positive with an undetectable viral load, and if so, if they had condomless anal sex with this person (or people).

Over half (62%) of HIV-positive men reported ever having a potential sex partner disclose PrEP use; slightly less than half (43%) of HIV-negative men reported ever having a potential sex partner disclose PrEP use. Out of all participants who reported a potential sex partner disclosing PrEP use, 16% of HIV-negative men and 45% of HIV-positive men said they had condomless anal sex with a partner they knew was on PrEP.

The majority of men, both HIV-negative (68%) and HIV-positive (90%) said they had ever had a potential sex partner disclose that they were HIV-positive with an undetectable viral load on a mobile app. Out of these men, 8.7% of HIV-negative men and 60% of HIV-positive men reported ever having condomless anal sex with one of those partners with an undetectable viral load.

Men in the study who had condomless sex with partners on PrEP or with undetectable viral loads appeared, most often, to let their assessment of HIV risk guide their decisions. In other words, most men weren’t having condomless sex because of negative attitudes toward condoms or lack of partner communication. They decided to have condomless sex after evaluating the protection afforded by their sex partner’s PrEP or TasP use, their own PrEP or TasP use, and knowledge that they could further reduce their HIV risk in the absence of condoms with seropositioning and serosorting.

“The most frequently endorsed theme across all categories was, ‘HIV risk is lower with biomedical prevention,’” said Newcomb and colleagues. One HIV-negative study participant said, “Based on the

recent studies regard[ing] undetectable transmission stats I felt it [condomless sex with an undetectable partner] is an acceptable risk.”

The study authors introduce the term “biomed-matching” to refer to sex partners that either both take PrEP or both are HIV-positive with undetectable viral loads.

One HIV-positive study participant reported that he, “only sleep[s] [with] guys who are on PrEP or undetectable”—substantially reducing the risk that he will transmit HIV to a sex partner whether or not condoms are used.

“HIV-positive MSM are choosing to have condomless anal sex with partners to whom they are less likely to transmit HIV because of partners’ use of biomedical strategies,” the authors write. “Mobile dating apps may provide a more efficient and less stigmatizing environment in which HIV-positive MSM can disclose their status and seek partners to whom transmission is less likely because of their use of PrEP or because their viral load is suppressed.”

Journal Reference:

Newcomb, M. E. and others. [Partner disclosure of PrEP use and undetectable viral load on geosocial networking apps: Frequency of disclosure and decisions about condomless sex](#). *Epidemiology and Prevention*. 2016.

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

PrEP use rising among high-risk gay men in Washington State

Liz Highleyman, [aidsmap.com](#) | 2.16

More than 20% of gay and bisexual men in Washington State considered to be at high risk for HIV infection were taking Truvada pre-exposure prophylaxis (PrEP) in 2015, and a large majority of both higher- and lower-risk men were aware of it, according to a study published in the January 28 edition of *AIDS*.

Daily Truvada (tenofovir/emtricitabine) PrEP has been shown to be more than 90% effective in preventing HIV infection among people who take it consistently. The US Food and Drug Administration (FDA) approved Truvada for PrEP in July 2012, but uptake was initially slow, as most people either did not know about PrEP or had concerns about its safety and efficacy. But PrEP use has accelerated in recent years in conjunction with community advocacy, especially among men who have sex with men (MSM).

Julia Hood of the Seattle and King County Public Health Department and colleagues assessed trends in PrEP awareness and use among gay and bisexual men in the US state of Washington – home to Seattle – which has the country's first PrEP drug assistance programme and a Medicaid programme that pays for PrEP.

The researchers conducted a cross-sectional survey annually at the Seattle Pride Parade between 2009 and 2015. The Gay Pride survey collects data on respondents’ demographic characteristics, access to healthcare, risk behaviours, HIV and sexually transmitted disease testing, and awareness of HIV prevention strategies and campaigns. The anonymous survey could be done by an interviewer or self-

administered in English or Spanish, and respondents received condoms, information about local services and a \$5 gift card.

This convenience sample included 2168 gay and bisexual men who reside in Washington State and said they had never tested HIV-positive. Most (71%) were white and the median age was 32. About half had a college education and a third reported an annual income over \$50,000. The majority (70%) lived in King County, which includes Seattle, the state's largest city.

About a quarter of the men met the health department's criteria for 'high risk' for HIV infection, which included having at least ten anal sex partners, condomless anal sex with a man who was HIV-positive or of unknown status, having a bacterial sexually transmitted infection, or using methamphetamine or poppers.

Prior to FDA approval of Truvada for PrEP in 2012, only five men reported having ever used PrEP (< 1% of 2009-2011 respondents). Yet by 2015, 26 out of 115 high-risk MSM – or 23% – said they were currently taking PrEP; 72% of men who reported ever using PrEP were currently doing so.

The percentage of high-risk men who reported ever taking PrEP increased from 5% in 2012 to 31% in 2015. PrEP use among lower-risk gay and bi men remained low and stable, between 1 and 3% during the period of 2012 to 2015.

In multivariate analyses PrEP use was associated with later calendar years (adjusted relative risk 2.29) and higher HIV risk (adjusted relative risk 2.29).

The percentage of high-risk gay and bi men who had heard of PrEP increased from 13% in 2012 to 86% in 2015, while the proportion of lower-risk men who were familiar with it rose from 29 to 58%.

"PrEP awareness is high and the use has rapidly increased over the last year among MSM in Seattle, Washington, USA," the study authors concluded. "These findings demonstrate that high levels of PrEP use can be achieved among MSM at high-risk for HIV infection."

The researchers added that a number of factors distinguish the survey area from much of the rest of the US, including a relatively well-educated and affluent population, a large number of medical providers offering PrEP, the state PrEP drug assistance programme and a Medicaid programme that pays for PrEP without co-payments, and a state health department campaign to raise PrEP awareness among gay men.

However, they noted that despite the dramatic recent increase in PrEP use among high-risk MSM, only 7% of all 2015 survey respondents said they were currently taking PrEP. As a limitation of the study, they said that gay and bi men who attend Pride events may differ from MSM who do not, and the survey included a relatively small number of black and Latino men – populations disproportionately affected by HIV nationwide.

"Achieving a population-level effect on HIV transmission may require substantially higher levels of use than we observed," the researchers wrote. "At the same time, modelling studies in the USA and Australia have suggested that given current drug costs, PrEP is only cost-effective if targeted to high-risk MSM. Our findings suggest that such targeting is occurring in King County, Washington, USA."

"However, some MSM categorized as being low risk in our analysis may be at significant risk for HIV acquisition," they continued. "Future efforts should focus both on increasing PrEP uptake among high-risk MSM and developing better criteria to identify segments of the MSM population that would benefit most from PrEP."

Reference:

Hood JE et al. Dramatic increase in preexposure prophylaxis use among MSM in Washington State. *AIDS* 30:515-519, January 28, 2016.

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

Vaginal Ring Provides Partial Protection from HIV in Large Multinational Trial

NIH-Funded Study Finds Protective Effect Strongest in Women over Age 25

Press Release, NIAID | 2.22

A ring that continuously releases an experimental antiretroviral drug in the vagina safely provided a modest level of protection against HIV infection in women, a large clinical trial in four sub-Saharan African countries has found. The ring reduced the risk of HIV infection by 27 percent in the study population overall and by 61 percent among women ages 25 years and older, who used the ring most consistently.

These results were announced today at the Conference on Retroviruses and Opportunistic Infections (CROI) in Boston and simultaneously [published online](#) in the *New England Journal of Medicine*.

"Women need a discreet, long-acting form of HIV prevention that they control and want to use," said Anthony S. Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health (NIH) and the primary funder of the trial. "This study found that a vaginal ring containing a sustained-release antiretroviral drug confers partial protection against HIV among women in sub-Saharan Africa. Further research is needed to understand the age-related disparities in the observed level of protection."

Women accounted for more than half of the 25.8 million people living with HIV in sub-Saharan Africa in 2014. Finding effective HIV prevention tools for adolescent girls and young women in particular is critical, as one in four new HIV infections in sub-Saharan Africa occur in this group.

The ASPIRE study, also known as MTN-020, aimed to determine whether the experimental antiretroviral drug dapivirine could safely and effectively prevent HIV infection when continuously released in the vagina from a silicone ring replaced once every 4 weeks. The study, which began in 2012, enrolled more than 2,600 HIV-uninfected women ages 18 to 45 years who were at high risk for HIV infection at 15 sites in Malawi, South Africa, Uganda and Zimbabwe. The women were assigned at random to receive either the dapivirine ring or a placebo ring. No one knew who received which ring until the end of the trial.

All study participants received a package of HIV prevention services at each study visit, including HIV risk-reduction counseling, partner HIV testing, treatment of sexually transmitted infections in participants and their partners, and free condoms.

The investigators found that the dapivirine ring reduced the risk of acquiring HIV by 27 percent among all women enrolled in the trial. But when the scientists excluded data from two sites where it was apparent early on that many women were not returning for study visits or using the ring consistently, the ring reduced the risk of HIV infection by 37 percent.

Furthermore, the investigators found that the dapivirine ring reduced the risk of HIV infection by 61 percent in women ages 25 and older, but provided no statistically significant protection in women younger than 25 years. These younger women appeared to use the ring less consistently than other participants, based on the amount of dapivirine measured in volunteers' blood during study visits.

To explore this age-related effect further, investigators performed analyses that were not originally planned and found that the ring reduced the risk of HIV infection by 56 percent in women older than 21 years, but provided no protection for women ages 18 to 21 years. More research is needed to determine whether behavior, biology or a combination of factors contributed to the lack of significant protection for younger women.

Finally, the investigators found that the rate of adverse medical events was similar among women who received the dapivirine ring compared to those who received the placebo ring, as was the frequency of antiretroviral resistance in women who acquired HIV.

“To help bring about an end to the HIV/AIDS epidemic, women—especially those in sub-Saharan Africa—need multiple options for HIV prevention,” said Jared Baeten, M.D., Ph.D., who co-led the study for the NIH-funded Microbicide Trials Network (MTN). “The ASPIRE study was an important step towards determining whether the dapivirine ring could become one such option.” Dr. Baeten is a professor of global health, medicine and epidemiology at the University of Washington in Seattle.

“The ASPIRE study is the first to demonstrate that a sustained drug delivery product that slowly releases an antiretroviral drug over time can offer partial protection from HIV,” added Thesla Palanee-Phillips, Ph.D., who led the study with Dr. Baeten. Dr. Palanee-Phillips is the director of network trials and research center programs at the Wits Reproductive Health and HIV Institute in Johannesburg, South Africa.

An ongoing large multinational clinical trial called The Ring Study also tested the dapivirine ring for safety and efficacy in women. Similar to ASPIRE, The Ring Study investigators found an overall effectiveness of 31 percent, with a slightly greater reduction in risk of HIV infection among women older than 21 years. The results of The Ring Study also were announced today at CROI.

NIAID plans to consult with a panel of outside experts to determine next steps for research on the dapivirine ring, which the International Partnership for Microbicides (IPM) developed and provided for both studies as their regulatory sponsor.

The ASPIRE study was funded by NIAID, the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development and the National Institute of Mental Health, all part of NIH, and conducted by MTN.

The Ring Study is being funded by the Bill and Melinda Gates Foundation, the U.S. President's

Emergency Plan for AIDS Relief, the U.S. Agency for International Development, and several European governments and organizations, and is being conducted by IPM.

For more information about the ASPIRE study, please see [Questions and Answers: The ASPIRE HIV Prevention Study](#), ClinicalTrials.gov using study identifier [NCT01617096](#), and the [MTN press release](#). For more information about The Ring Study, please see the [IPM press release](#).

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

Major disparities persist in lifetime risk of HIV diagnosis in the US

Liz Highleyman, aidsmap.com | 2.24

The lifetime risk of being diagnosed with HIV in the US has decreased overall during the past decade, falling to 1 in 99, according to a study from the Centers for Disease Control and Prevention (CDC) presented at the Conference on Retroviruses and Opportunistic Infections (CROI 2016) this week in Boston. The risk varies widely among population sub-groups, however, and half of black gay and bisexual men are likely to become infected if current trends persist.

Kristen Hess and colleagues used HIV diagnosis and death rates from the National HIV Surveillance System, National Center for Health Statistics and population census data to estimate the lifetime risk of being diagnosed with HIV, looking at sub-groups based on sex, age and race/ethnicity, as well as by state. These are the first-ever comprehensive national estimates of the lifetime risk of HIV diagnosis for several key populations at risk, according to the CDC.

The number of HIV diagnoses and deaths between 2009 and 2013 were used to calculate the probability of an HIV diagnosis at a given age. The lifetime risk estimate is the cumulative probability of being diagnosed with HIV from birth to death, assuming diagnosis rates remain constant. The new estimates were compared to findings from an analysis done in 2004-2005.

The researchers found that the overall lifetime risk of an HIV-positive diagnosis was lower than it was a decade ago, falling from about 1 in 78 during 2004-2005 to 1 in 99 during 2009-2013.

But “major disparities persist” across sub-groups, Hess told a CROI press conference.

Across all racial/ethnic groups, the lifetime risk of HIV diagnosis was higher for men (1 in 64) than for women (1 in 227).

African Americans had the highest lifetime risk of any racial/ethnic group, 1 in 20 for black men and 1 in 48 for black women. Estimated diagnosis rates among Hispanics/Latinos (1 in 48 for men and 1 in 227 for women) and Pacific Islanders (1 in 82 for men and 1 in 385 for women) were lower, but still considerably higher than the risk for white people (1 in 132 for men and 1 in 880 for women) or Asian Americans (1 in 174 for men and 1 in 883 for women). Native American men had about the same risk as white men (1 in 129), while Native women had a much higher risk than white women (1 in 399).

The analysis confirmed that men who have sex with men are most heavily affected by the HIV epidemic, with a 1 in 6 chance of ever being diagnosed – nearly 80 times more likely than heterosexual men.

Breaking the categories down further, black gay and bisexual men had the highest risk of any subgroup, with 1 in 2 expected to be diagnosed over a lifetime. For Latino gay men the risk was 1 in 4 and for Pacific Islander men it was 1 in 7. Whites (1 in 11), Native Americans (1 in 12) and Asians (1 in 14) had the lowest lifetime likelihood of diagnosis among gay men.

People who inject drugs also had a much higher lifetime risk than the population as a whole, 1 in 36 for men and 1 in 23 for women. For black drug injectors the risk was 1 in 9 for men and 1 in 6 for women. Unlike the population overall, in this sub-group women had a higher risk of HIV diagnosis than men.

Heterosexuals who did not report injection drug use had a much lower risk of diagnosis (1 in 473 for men and 1 in 241 for women). But again, the likelihood was higher for African Americans (1 in 86 for men and 1 in 49 for women) while whites had very low lifetime risk (1 in 2514 for men and 1 in 1083 for women).

The researchers did not report separate figures for lesbians or for transgender men or women.

Looking at data by state, lifetime diagnosis risk ranged from a low of 1 in 670 in North Dakota to a high of 1 in 49 in Maryland. People living in the southeast were more likely to be diagnosed than people in other regions, while those in the northwest were least likely. The highest risk of all was seen in Washington, DC, at 1 in 13.

Looking at “age-conditional” risk of HIV diagnosis, or the likelihood during the next 10 years, risk was highest for gay men at age 20 (1 in 15) compared with those at age 30 (1 in 21), age 40 (1 in 26) and age 50 (1 in 55). However, among men who inject drugs, the risk increased with age, perhaps indicating late diagnosis.

“Lifetime risk may be a useful tool to more effectively communicate the risk of HIV to the general public” and “can help to highlight the severe disparities”, the researchers concluded.

“As alarming as these lifetime risk estimates are, they are not a foregone conclusion. They are a call to action,” Dr Jonathan Mermin, director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention said in a CDC press release. “The prevention and care strategies we have at our disposal today provide a promising outlook for future reductions of HIV infections and disparities in the US, but hundreds of thousands of people will be diagnosed in their lifetime if we don't scale up efforts now.”

“These estimates are a sobering reminder that gay and bisexual men face an unacceptably high risk for HIV – and of the urgent need for action”, added Dr Eugene McCray, director of CDC's Division of HIV/AIDS Prevention. “If we work to ensure that every American has access to the prevention tools we know work, we can avoid the outcomes projected in this study.”

References

Hess K et al. *Estimating the lifetime risk of a diagnosis of HIV infection in the United States*. Conference on Retroviruses and Opportunistic Infections (CROI), Boston, abstract 52, 2016.

[View the abstract on the conference website.](#)

[View a webcast of this session on the conference website.](#)

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

Scientific Papers/Conference Abstracts

Privacy and Confidentiality Practices In Adolescent Family Planning Care At Federally Qualified Health Centers

Beeson T, Mead KH, Wood S, et al. *Perspectives on Sexual and Reproductive Health* 2016;48(1):
DOI:10.1363/48e7216

CONTEXT:

The confidentiality of family planning services remains a high priority to adolescents, but barriers to implementing confidentiality and privacy practices exist in settings designed for teenagers who are medically underserved, including federally qualified health centers (FQHCs).

METHODS:

A sample of 423 FQHCs surveyed in 2011 provided information on their use of five selected privacy and confidentiality practices, which were examined separately and combined into an index. Regression modeling was used to assess whether various state policies and organizational characteristics were associated with FQHCs' scores on the index. In-depth case studies of six FQHCs were conducted to provide additional contextual information.

RESULTS:

Among FQHCs reporting on confidentiality, most reported providing written or verbal information regarding adolescents' rights to confidential care (81%) and limiting access to family planning and medical records to protect adolescents' confidentiality (84%). Far fewer reported maintaining separate medical records for family planning (10%), using a security block on electronic medical records to prevent disclosures (43%) or using separate contact information for communications regarding family planning services (50%). Index scores were higher among FQHCs that received Title X funding than among those that did not (coefficient, 0.70) and among FQHCs with the largest patient volumes than among those with the smallest caseloads (0.43). Case studies highlighted how a lack of guidelines and providers' confusion over relevant laws present a challenge in offering confidential care to adolescents.

CONCLUSIONS:

The organizational practices used to ensure adolescent family planning confidentiality in FQHCs are varied across organizations.

View the paper online: [Abstract](#)

Providing ART to HIV Seropositive Persons Who Use Drugs: Progress in New York City, Prospects for "Ending the Epidemic"

Jarlais DCD, Arasteh K, McKnight C, et al. *AIDS and Behavior* 2016;20(2):353-362

Abstract:

New York City has experienced the largest HIV epidemic among persons who use psychoactive drugs. We examined progress in placing HIV seropositive persons who inject drugs (PWID) and HIV seropositive

non-injecting drug users (NIDU) onto antiretroviral treatment (ART) in New York City over the last 15 years. We recruited 3511 PWID and 3543 NIDU from persons voluntarily entering drug detoxification and methadone maintenance treatment programs in New York City from 2001 to 2014. HIV prevalence declined significantly among both PWID and NIDU. The percentage who reported receiving ART increased significantly, from approximately 50 % (2001–2005) to approximately 75 % (2012–2014). There were no racial/ethnic disparities in the percentages of HIV seropositive persons who were on ART. Continued improvement in ART uptake and TasP and maintenance of other prevention and care services should lead to an “End of the AIDS Epidemic” for persons who use heroin and cocaine in New York City.

View the paper online: [Abstract](#)

A Comparison of Men Who Have Sex with Men, People Who Inject Drugs and High-Risk Heterosexuals' Risk for HIV Infection, San Francisco

Raymond HF, Ick TO, Chen YH. *AIDS and Behavior* 2016;20(2):417-422

Abstract:

HIV in the United States is concentrated in populations such as men who have sex with men (MSM), people who inject drugs (PWID), women of color and people living in poverty. These populations are labeled high-risk for HIV infection because of the higher levels of HIV or HIV risk taking behaviors seen in these groups compared to other sub-populations. It is also possible that a group may engage in behaviors that are “high-risk” for HIV infection but never become infected since HIV is not present or not present to a great extent in their social or sexual networks. We analyzed samples of MSM, PWID and high-risk heterosexuals (HRH) collected through the National HIV Behavioral Surveillance (NHBS) system in San Francisco to examine HIV risk taking and HIV burden to determine if the label “high-risk” is appropriately applied. NHBS samples MSM using time location sampling and PWID and HRH using Respondent Driven Sampling. We sampled 508 MSM in 2011, 570 PWID in 2012 and 267 HRH in 2013. There were, as expected, differences in demographic characteristics across the three groups. HRH had a greater number of high-risk behaviors compared to MSM and PWID but had the lowest HIV prevalence. Focusing on risk behavior alone to label populations without considering the background HIV prevalence in communities, the types of risks engaged in and actual HIV infections may obscure which populations truly merit the label “high-risk” for HIV infection.

View the paper online: [Abstract](#)

Hypersexual, Sexually Compulsive, or Just Highly Sexually Active? Investigating Three Distinct Groups of Gay and Bisexual Men and Their Profiles of HIV-Related Sexual Risk

Parsons JT, Rendina HJ, Ventuneac A, et al. *AIDS and Behavior* 2016;20(2):262-272

Abstract:

Emerging research supports the notion that sexual compulsivity (SC) and hypersexual disorder (HD) among gay and bisexual men (GBM) might be conceptualized as comprising three groups—Neither SC nor HD; SC only, and Both SC and HD—that capture distinct levels of severity across the SC/HD continuum. We examined data from 370 highly sexually active GBM to assess how the three groups compare across a range of risk factors for HIV infection. Comparisons focused on psychosexual measures—temptation for condomless anal sex (CAS), self-efficacy for avoiding CAS, sexual excitation

and inhibition—as well as reports of actual sexual behavior. Nearly half (48.9 %) of this highly sexually active sample was classified as Neither SC nor HD, 30 % as SC Only, and 21.1 % as Both SC and HD. While we found no significant differences between the three groups on reported number of male partners, anal sex acts, or anal sex acts with serodiscordant partners, the Both SC and HD group reported higher numbers of CAS acts and CAS acts with serodiscordant partners and also had a higher proportion of their anal sex acts without condoms compared to the SC Only group. Our findings support the validity of a three-group classification system of SC/HD severity in differentiating psychosexual and HIV-related sexual risk behavior outcomes in a sample of GBM who report similarly high levels of sexual activity. Notwithstanding the need for sex positive HIV prevention programs, interventions that attempt to help Both SC and HD men deal with distress and address their psychosexual needs specifically may derive HIV prevention benefits.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

New edition of HIV & sex booklet

A new edition of our HIV & sex booklet is now available online, and in print through our patient information scheme. Read it online at www.aidsmap.com/booklets

What's it all about?

It's all about sex! This booklet is an introduction to sexual health for people living with HIV.

Whether you've only recently found out you have HIV, or have known for a while, having sex and relationships in your life is likely to be as important for you as it ever was. Your sexuality is part of what makes you human.

Since the last edition of this booklet was published, there has been more research around HIV treatment and its impact on HIV transmission. Throughout the booklet, we have been able to give more confident messages around this issue.

For more information: [Click here](#)

Pre-conference registration is now open

Registration for the [21st International AIDS Conference \(AIDS 2016\)](#) official pre-conference meetings is now open! This year, AIDS 2016 is taking a new approach to the traditional pre-conferences, offering a more formal programme to enhance the delegate experience.

For the first time, a selected group of independently organized pre-conference meetings will be held within the main conference venue over the weekend of 16 and 17 July, immediately preceding AIDS 2016. This year's official pre-conferences represent a diversity of scientific, technical, and community interests and we are delighted to announce the official [AIDS 2016 pre-conference programme](#) line-up

and provide you with a step-by-step guide on [how to register](#).

THE PRE-CONFERENCE PROGRAMME

Please find the pre-conference programme below. For more information about each meeting, visit the [AIDS 2016 pre-conference page here](#).

Open pre-conference meetings

The open pre-conference meetings are open to conference delegates on a first-come, first-served basis.

- Action + Access: Rights and Demands of Gay and Bisexual Men in the Global HIV Response organized by Men Who Have Sex With Men Global Forum (MSMGF)
Saturday 16 July
- In Our Voice: Positive Stories! Positive Teens! Positive Lives! organized by Bristol-Myers Squibb (BMS)
Sunday 17 July
- The 3rd International HIV/Viral Hepatitis Co-Infection Meeting organized by the International AIDS Society (IAS)
Sunday 17 July
- No More Lip Service: Trans Access, Equity and Rights, Now! organized by the International Reference Group on Transgender Women and HIV/AIDS (IRGT)
Sunday 17 July
- TB2016 organized by the International AIDS Society (IAS)
Saturday, 16 and Sunday, 17 July

Application required pre-conference meetings

The application required meetings indicate that the pre-conference organizers have sole discretion to add you as an attendee following your registration submission.

- NursingHIV 2016 organized by the Democratic Nursing Organisation of South Africa (DENOSA), the International Center for AIDS Care and Treatment Programs (ICAP), the Association of Nurses in AIDS Care (ANAC) and the International Council of Nurses (ICN)
Saturday 16 July
- UN 90-90-90 Target Workshop: A Vehicle for Knowledge Translation of Treatment and Prevention organized by the British Columbia Centre for Excellence in HIV/AIDS (BC-CfE)
Sunday 17 July
- Towards an HIV Cure Symposium organized by the International AIDS Society (IAS)
Saturday, 16 and Sunday, 17 July
- LIVING 2016: The Positive Leadership Summit organized by the Global Network of People Living with HIV (GNP+)
Saturday, 16 and Sunday, 17 July

HOW TO REGISTER

Registration to attend the pre-conferences is done through the official [AIDS 2016 registration system](#). Please be sure to register early to secure your seat. For individuals not attending the full conference, a

pre-conference pass is available for purchase, which will allow access to the full conference venue and a maximum of three pre-conferences. Delegates with a full registration or a pre-conference registration will be able to register for up to three pre-conference meetings. Below is a step-by-step guide to register:

- **Step 1:** Before you can register, you need to create a conference profile [here](#). If you already have a conference profile from previous International AIDS Society (IAS) or International AIDS conferences, you will be able to use the same login credentials [here](#).
- **Step 2:** Submit your registration and payment in full for either the full AIDS 2016 conference or the pre-conference pass.
- **Step 3:** Check that your registration status is confirmed by looking in the upper right hand corner in the Registration section on your profile home page. It should read "You have registered".
- **Step 4:** If your registration status is confirmed, scroll down your profile home page to the pre-conferences selection tab and click to "Read Details". If your registration is still not confirmed, contact preconferences@AIDS2016.org for support.
- **Step 5:** At this stage, you are not registered for any pre-conferences. In the pre-conferences tab, move over to "Click here to update your pre-conferences registrations." Click the link to access the list of pre-conferences and read the descriptions, check their dates, and **select up to a maximum of three pre-conferences**.

PLEASE NOTE: For meetings that require an application to register, the pre-conference organizers have sole discretion to add you as an attendee. A pop-up application will direct you to email the organizer or fill out an application form and the pre-conference organizer will contact you directly.

- **Step 6:** Once you have selected the pre-conference meetings of your choice, check the box that you agree to the Terms & Conditions and click "Submit". The next page will confirm that you were added to the selected pre-conferences. Proceed back to your profile home page to view your pre-conference selections listed in the pre-conferences tab.

Still have questions? Not to worry, we are hosting an [AIDS 2016 pre-conference webinar on Tuesday, 1 March 2016, 14:00 CET](#) to provide further details and answer all of your remaining questions. Please join the webinar [here](#).

Be sure to visit www.AIDS2016.org over the coming months for additional pre-conference programme and scheduling details. For any questions regarding pre-conference registration please contact us at preconferences@AIDS2016.org.

We look forward to seeing you in Durban!

Sincerely,
AIDS 2016 conference organizers

New & Updated STD Resources from CDC

[Introducing Technology into Partner Services: A Toolkit for Programs](#) – This updated toolkit serves as a general resource for using the Internet and other digital technologies, such as mobile phones and social networking sites, to trace and contact persons potentially exposed to STDs and HIV. It is especially useful for health departments, community-based organizations and others who provide HIV/STD partner services.

[2014 STD Surveillance Report Slides](#) – Series of PowerPoint slides includes graphs and maps from the 2014 STD Surveillance Report. These presentation-ready slides include data about chlamydia, gonorrhea, syphilis, and other STDs, as well as information about STDs in women and infants, adolescents and young adults, ethnic minorities, and men who have sex with men.

[The Lowdown on How to Prevent STDs](#) – This web-based infographic provides readers with basic information about STD prevention in an easy-to-read format. It can be added to your website, or used in your social media outreach efforts.

[STDs During Pregnancy](#) – The updated, detailed fact sheet provides physicians with specific STD testing and treatment recommendations for their patients.

[Questions & Answers: 2015 STD Treatment Guidelines](#) – STD clinical experts in the National Network of STD Clinical Prevention Training Centers (NNPTC) and CDC subject matter experts respond to frequently asked questions about The 2015 STD Treatment Guidelines on this website.

[CDC Expert Commentary: Keep an Eye Out For Ocular Syphilis](#) – Subject matter experts Dr. Thomas Peterman and Dr. Kimberly Workowski discuss the recent increase in ocular syphilis cases and provide physicians with information on diagnosis and treatment in a commentary published by Medscape. [Note: Medscape membership is required to see this article; however, you can sign-up for a free account.]

[Effective Interventions to Reduce Sexually Transmitted Disease](#) - The journal of *Sexually Transmitted Diseases* recently published a special supplement that summarizes published evidence for the effectiveness of various STD control interventions. In a time with fewer resources and more prevention options than ever, this information offers a menu of options to help programs identify which interventions best meet their needs

[CDC Email Updates](#) – You can now sign up for updates on STD Program Information.

I hope you find these resources useful. I'd also like to take this time to remind you that STD Awareness Month is right around the corner. This is our time to bring a renewed sense of enthusiasm and focus to our collective STD awareness and prevention efforts. CDC will promote a theme of "Talk. Test. Treat." to encourage both individuals and providers to follow these three steps to reduce and prevent STDs. We will send more information about the theme and resources for you to use in the coming weeks, but you can get a jump start by visiting [CDC-INFO on Demand](#) to order free posters, stickers, and postcards that can be displayed in your schools, clinics, community organizations, and health departments to promote STD Awareness Month.

Thank you for your commitment to CDC's Division of STD Prevention.

Gail Bolan, M.D.
Director, Division of STD Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

Job/Internship Postings

Clinical Regional Coordinator – CAPTC

Organization: California Prevention Training Center (PHFE & UCSF)
Location: Oakland, CA
Salary: \$65,000 - \$75,000
App. Deadline: Open until filled

DESCRIPTION

SUMMARY

The California Prevention Training Center (CA PTC) is jointly sponsored by Public Health Foundation Enterprises, Inc. (PHFE) and the University of California, San Francisco (UCSF). Federally funded by the Centers for Disease Control and Prevention (CDC), the CAPTC is an integral part of a National Network of Prevention Training Centers that provide clinical, disease intervention services and capacity-building assistance through training and technical assistance to medical, health, and community professionals to enhance their STD/HIV knowledge and skills.

The Clinical Regional Coordinator is responsible for coordinating all clinical training and technical assistance activities in CAPTC's assigned 5 state region (Arizona, California, Hawaii, Nevada, and New Mexico), including needs assessment activities to guide course planning and development. The coordinator regularly interacts with local, state and national partners to ensure delivery of high quality training and technical assistance in the arena of STD screening, diagnosis, and treatment.

ESSENTIAL FUNCTIONS

Project Management (50%) Responsible for:

- Establishing and maintaining excellent working relationships with training partners in the 5-state CAPTC clinical training region (AZ, CA, HI, NM, NV), including STD directors at state and local health departments, community health centers, health maintenance organizations and other health care organizations likely to diagnose, treat, and manage patients with STDs
- Makes strategic contributions and implements CAPTC Clinical Regional Center program objectives based on work plan deliverables and CDC grant requirements
- Coordination and delivery of clinical trainings and events in consultation with CAPTC clinical faculty and guest faculty (knowledge of instructional design, adult learning theory, and interactive teaching methods strongly desired)
- Development, implementation, and management of evaluation instruments to determine extent to which training activities are achieving course outcomes, in collaboration with the Evaluation Manager or designated evaluation staff
- Completion of interim and annual progress reports and other grant-related documents as required by the CDC and CAPTC, in coordination with CAPTC director, medical director, evaluation manager and other designated clinical PTC faculty

- Coordination of Clinical Consultation service via phone and email for regional providers, including ensuring responsiveness (follow-up within or before 24 hours)
- Implementation of assessment activities to determine priority STD training needs of medical providers in five-state region, including compiling data, summarizing results, and meeting with clinical faculty and director to determine best ways to achieve recommendations
- Participation in the National Network of Prevention Training Center (NNPTC) steering committee and clinical training network

POSITION REQUIREMENTS

JOB QUALIFICATIONS

Education/Experience

- Master's degree in Public Health (MPH) or related field desirable
- Three years of work experience in sexual and reproductive health, STD, HIV prevention, public health, or health-related programs
- Experience working with or in healthcare organizations in training or quality improvement
- Experience working in a regional or national training program to improve health provider practice in STD, HIV, reproductive health or other health-related services for patients

Certificates/Licenses/Clearances: N/A

Other Skills, Knowledge, and Abilities

- Extensive project management experience and strong organizational skills
- Basic knowledge of public health principles and communicable diseases, including sexually transmitted diseases
- Knowledge of instructional design, adult learning theory, and interactive teaching methods
- Excellent oral, written and presentation skills for working with participants, faculty, partners and stakeholders.
- Must be a team player, but possess ability to work independently in a dynamic, fast-paced environment.
- Strong user skills for technological support systems, including health information tools, website, twitter, audience response systems, webinar and conference call systems
- Must have proven abilities with MS Office Programs
- Must have the ability to assume initiative, develop and maintain effective working professional relationships

PHYSICAL DEMANDS

Stand Frequently

Walk Frequently

Sit Frequently

Handling / Fingering Occasionally

Reach Outward Occasionally

Reach Above Shoulder Occasionally

Climb, Crawl, Kneel, Bend Occasionally

Lift / Carry Occasionally - Up to 50 lbs

Push/Pull Occasionally - Up to 50 lbs

See Constantly

Taste/ Smell Not Applicable

Not Applicable Not required for essential functions
Occasionally (0 - 2 hrs/day)
Frequently (2 - 5 hrs/day)
Constantly (5+ hrs/day)

WORK ENVIRONMENT

General Office Setting, Indoors Temperature Controlled

APPLICATION PROCEDURE

Interested individuals should submit a resume and cover letter for consideration.

PHFE is an Affirmative Action, Equal Opportunity Employer that encourages minorities, women, veterans, and disabled to apply

For more information: [Click here](#)

Health Program Coordinator III (Project PrIDE Coordinator) - SFDPH

Organization: San Francisco Department of Public Health
Location: San Francisco, CA
Salary: \$85,670.00 - \$104,156.00/year

The Department of Public Health is accepting applications for one (1) permanent exempt full-time position in Class 2593 Health Program Coordinator III for Project PrIDE.

Under the direction of the San Francisco City Clinic Medical Director, this position will be responsible for planning, developing, implementing, maintaining and monitoring the implementation of Project PrIDE, a project funded by the Centers for Disease Control and Prevention (CDC). Project PrIDE supports two endeavors critical to San Francisco's "Getting to Zero" campaign: 1) Scale up of pre-exposure prophylaxis (PrEP) and 2) Implementation of "data to care" activities to enhance linkage to and retention in HIV care. This position will primarily be responsible for implementation, monitoring and evaluation of the PrEP portion of the project. Deliverables of the PrEP portion of the project include:

- Increasing capacity of SFDPH to implement PrEP support activities for people at substantial risk of HIV, especially men who have sex with men (MSM) and transgender female (TF), particularly persons of color (the "target population");
- Increasing knowledge and awareness of PrEP for HIV prevention among the target population;
- Increasing provider knowledge and awareness of PrEP, and training in clinical management of PrEP for HIV prevention among providers;
- Establishing policies, procedures and protocols to implement PrEP support activities for the target population;
- Increasing number of providers trained to offer PrEP to the target population; AND
- Increasing number of PrEP prescriptions for the target population.

The Project PrIDE Coordinator will be responsible for overseeing day-to-day activities of the project. This position will work with the Project Director and leadership team to manage the PrEP project, develop the protocols, policies, and procedures for the project, ensure communication throughout the team,

coordinate meetings and activities, and serve as a liaison between the multiple partners who will make this project possible. This position will be the main point of contact for all communication and evaluation activities for this project, and will closely track progress on performance measurement activities with the support of the Project Director. The Project PrIDE Coordinator will also play an active role in all continuous quality improvement (CQI) activities.

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

LOCATION: 25 Van Ness Ave, San Francisco

SHIFT: 8:00am – 5:00pm Monday-Friday

This position performs the following essential duties:

- Supervises the PrEP navigator.
- Conducts a detailed analysis of the data related to barriers to PrEP usage for our target population in collaboration with a senior epidemiologist.
- Assists with planning and implementing a social marketing campaign, a Popular Opinion Leader program and a PrEP ambassador “peer navigator” program to increase knowledge and demand for PrEP in the target population.
- Improves the program’s ability to educate and directly link members of the target population to PrEP services.
- Implements a series of data-based strategies to assist SFDPH with identifying and reaching out to those with the greatest need for PrEP.
- Organizes and facilitates quarterly meetings of PrEP and HIV care navigation.
- Develops standardized protocols and shares best practices for PrEP navigation and HIV care navigation work.
- Works with the Center for Learning and Innovation at SFDPH to develop and manage a community of practice for PrEP and HIV care navigators.
- Provides technical assistance to clinic directors who are interested in implementing PrEP.
- Helps build provider capacity to offer PrEP by assisting with implementation of an academic detailing program.
- Communicates clearly and in a professional manner with staff throughout the Population Health Division, with the Getting to Zero consortium and with consumers and clinicians.
- Participates as a member of Getting to Zero PrEP committee.
- Maintains a detailed and well-organized schedule of tasks and events.
- Tracks project revenues and expenses and prepares budget reports.
- Participates in calls with the CDC project officer.

The Health Program Coordinator III (Project PrIDE Coordinator) also performs other related duties as assigned.

Minimum Qualifications

1. Possession of a baccalaureate degree from an accredited college or university; **AND**
2. Three (3) years 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 master's degree, from an accredited college or university, with a specialty in prevention or public health.
- Knowledge of program coordination, planning, development and evaluation.
- Knowledge of STD and HIV and medical terminology.
- Knowledge of pre-exposure prophylaxis (PrEP).
- Excellent verbal and written communication skills.
- Supervisory experience.
- Substantial experience with the manipulation of complex word processing files, spreadsheets, and databases.
- Ability to work as part of a team, to prioritize and handle multiple tasks, and to work independently in a high-pressure environment.
- Sensitivity to and experience working with the ethnically, culturally and sexually diverse individuals, communities, agencies and organizations.
- Ability to perform and prioritize multiple tasks.
- Experience with budget and grant preparation and administration.

How To Apply

Applications for City and County of San Francisco jobs are **only** 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, Stephanie Cohen, at (415) 487-5503 or email: Stephanie.Cohen@sfdph.org.

For more information: [Click here](#)

Epidemiologist / Medical Epidemiologist- NCHHSTP/DSTDP

Organization: Centers for Disease Control and Prevention (CDC)
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Division of STD Prevention, Epidemiology and Statistics Branch

Location: Atlanta, GA

The Division's activities related to the epidemiology of *Neisseria gonorrhoeae*. The position is located in the Epidemiology Research Team. The incumbent will be responsible for scientific and programmatic work related to the epidemiology and control of *Neisseria gonorrhoeae*. The incumbent will work closely with the laboratory and surveillance branches and will provide the primary scientific and programmatic leadership in the development of response related projects. Experience with organizing and supervising field projects, collaboration with laboratory partners, management of programmatic projects, and scientific communication skills are important for this position.

Location: Atlanta, Georgia Corporate Square Campus

Qualification requirements:

Candidates must have a PhD in epidemiology (or related discipline) or an MD or DO. Experience in working with state and local health departments as well as management of programmatic activities integrating laboratory, epidemiology, surveillance, and field work is critical. Experience with STDs (particularly Neisseria gonorrhoeae) is desirable.

Percent of travel required: Travel will be less than 10% of time.

*US citizens and non-US citizens are eligible to apply. Interested candidates can submit their application (CV and coverletter) to Billy Litchfield (brl1@cdc.gov) by **Friday March 11, 2016***

Selection/Acceptance Process: Applications will be reviewed and interviews may be conducted among top candidates. Relocation is not supported.

Positions will be hired as Title 42 FTEs. Position is proposed for 5 years, and is renewable in not to exceed 10 total years.

For more information about this position, please contact:

Kyle Bernstein, 404-639-8325 (kio8@cdc.gov)

Epidemiologist - NCHHSTP/DSTD

Organization: Centers for Disease Control and Prevention (CDC)
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Division of STD Prevention, Epidemiology and Statistics Branch

Location: Atlanta, GA

The Division of STD Prevention (DSTD), Epidemiology and Statistics Branch, is seeking an epidemiologist to support the Division's activities related to the epidemiology of *Neisseria gonorrhoeae*. The position is located in the Epidemiology Research Team. The incumbent will work closely with the laboratory and surveillance branches and will support scientific and programmatic leadership in the development of response related projects. Strong communication and organizational skills are critical, experience working with local or state health departments and STDs is desirable.

Location: Atlanta, Georgia Corporate Square Campus

Qualification requirements:

Candidates must have a Master's degree in Epidemiology (or a related discipline). Experience with STDs (particularly *Neisseria gonorrhoeae*) is desirable.

Percent of travel required: Travel will be less than 10% of time.

US citizens and non-US citizens are eligible to apply. Interested candidates can submit their application (CV and coverletter) to Billy Litchfield (brl1@cdc.gov) by **Friday March 11, 2016**

Selection/Acceptance Process: Applications will be reviewed and interviews may be conducted among top candidates. Relocation is not supported.

Positions will be hired as Title 42 FTEs. Position is proposed for 5 years, and is renewable in not to exceed 10 total years.

For more information about this position, please contact:

Kyle Bernstein, 404-639-8325 (kio8@cdc.gov)

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

Confidentiality Notice Warning: This transmission may contain confidential and proprietary information intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you have received this transmission in error, any disclosure, copying, distribution, downloading, uploading or the taking of any action in reliance on the contents of this information is strictly prohibited, and you are requested to immediately notify the above sender.

To add colleagues' names, or unsubscribe, write me. If you have an article or job notice related to STD/HIV prevention which you would like included, please send. I'm sorry, but no bibliographic questions, please. I cut, paste, but don't write content. No endorsement should be implied! Select stories included are provided by kaisernetwork.org, a free service of The Henry J. Kaiser Family Foundation. The Kaiser Daily Health Policy Report is published for kaisernetwork.org by National Journal Group Inc. © 2011 by National Journal Group Inc. & Kaiser Family Foundation. Additionally, this email may include summaries from the CDC HIV/STD/TB Prevention News Update. <<http://www.cdcnpin.org/scripts/News/NewsList.asp>> for other articles. All rights reserved.

Note: Some words may have been replaced in [brackets] or with blanks (___) in order to avoid filtering by email inboxes.