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## California Stories

### CDCR: Condom dispensing program to begin at Tehachapi prison March 21

Alan Prock, Kern Golden Empire | 3.8

Officials with the California Department of Corrections and Rehabilitation say their condom program will begin at CCI Tehachapi March 21.

Under Assembly Bill 966, which took effect in 2014, the CDCR had to develop a five-year-plan to extend the availability of condoms in all state prisons.

Sexual contact between inmates is illegal and a high-risk behavior that threatens the health and welfare of the inmate population, CDCR staff and the public, according to a news release. HIV, hepatitis C, and other sexually transmitted infections are prevalent in correctional settings. In fact, one in seven people in the U.S. with HIV pass through the correctional system each year. According to the Centers for Disease Control and Prevention, extending the availability of condoms will help reduce transmission of these infections within CDCR facilities.

The program has been implemented at San Quentin State Prison, California Medical Facility, California State Prison-Corcoran, Mule Creek State Prison, Avenal State Prison, Pleasant Valley State Prison and California Substance Abuse Treatment Facility and State Prison in Corcoran general population yards. It will be implemented at the remaining institutions incrementally.

Inmates will be allowed no more than three state-issued, standard- sized, latex condoms at any given time. Dispensers will be wall-mounted in locations determined by each institution.

The dispensers and condoms will cost approximately \$128,240 for the initial purchase and implementation, which equates to approximately \$1.17 per inmate. Expenditures past the initial year will vary, but the cost is approximately \$138.00 per case of 1,008 condoms.

The cost to treat an inmate with hepatitis C can run approximately \$1,000 per day or more than \$84,000 for a 12-week course of treatment for one patient. Some patients require longer treatment, increasing the cost. This cost does not include lab tests, imaging studies and staff time. The wholesale cost of HIV treatment regimens range from \$24,000 to \$60,000 per person/per year, depending on which course of treatment is needed. None of these costs include lab tests and staff time. The cost of allowing all CDCR inmates access to condoms for one year is less than treating two patients who have hepatitis C or three patients who have HIV.

Although condoms are being made available to the inmate population, any sexual contact among inmates remains prohibited under CDCR regulations and the California Penal Code.

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

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## National Stories

### Genetic Research Into Early AIDS Cases Further Debunks “Patient Zero” Myth

As reported by POZ | 3.9

A genetic study of blood samples taken from the 1970s gives a clearer picture of how the epidemic unfolded in the United States, and the results further disprove the idea that a single person—a sexually voracious “Patient Zero”—spread the virus across America.

The findings were presented at the 2016 Conference on Retroviruses and Opportunistic Infections (CROI) in Boston.

Researchers led by evolutionary biologist Michael Worobey, PhD, of the University of Arizona in Tucson looked at blood samples taken from gay and bisexual men in 1978 and 1979 as part of a hepatitis B study. They also looked at a blood sample taken from a Canadian flight attendant named Gaëtan Dugas, a.k.a. Patient Zero.

A 1987 book by Randy Shilts about the AIDS epidemic, *And the Band Played On*, had identified Dugas as the “Typhoid Mary” of AIDS in North America, a myth that took hold in the public’s mind. In fact, as POZ reported earlier, it wasn’t until the 2013 book *Plane Queer: Labor, Sexuality, and AIDS in the History of Male Flight Attendants* that Shilt’s then-editor Michael Denny admitted that Patient Zero was cooked up to boost sales.

Worobey’s research offers further proof to debunk the myth. Looking at the blood samples, they created a family tree of the virus. Dugas fell in the middle of the tree, not at the beginning.

The genetic snapshot showed that HIV likely moved from Africa to the Caribbean by 1967 before then moving to New York City by 1971, and from there another single virus moved to San Francisco around 1975. In New York City, the virus spread enough to exhibit genetic diversity by the end of the 1970s.

“In the context of these insights into the early spread of HIV/AIDS in North America,” write the researchers in their [abstract](#), “the genesis and persistence of beliefs about ‘Patient 0’...are unsupported by scientific data.”

Below, you can watch a clip of Dugas speaking at a 1983 AIDS community event in Vancouver. The video is part the “[30 30 Campaign](#),” created in 2013 to celebrate the 30th anniversary and HIV history of AIDS Vancouver.

**View the story and watch the video online:** [Click here](#)

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### Women need more of the HIV drug Truvada than men to prevent infection

As reported by Medical News Today | 3.4

Women need daily doses of the antiviral medication Truvada to prevent HIV infection while men only need two doses per week due to the way the drug accumulates in different body tissues, according to a new study from pharmacy researchers the University of North Carolina at Chapel Hill.

The study, published in the Journal of Infectious Diseases, represents an important paradigm shift for HIV prevention strategies and could have major implications for clinical trial designs, said Angela Kashuba, Pharm.D., senior author of the study and the John and Deborah McNeill Distinguished Professor at the UNC Eshelman School of Pharmacy.

"Our data highlight the fact that one dose does not fit all," Kashuba said. "In determining how best to use drugs to protect people from HIV, we need to understand where in their body they are at risk for being infected, along with the concentration of drug that is needed to protect that site from infection."

Previous clinical studies showed that Truvada, the only prophylactic drug approved by the Food and Drug Administration to help prevent the spread of HIV, was more effective at reducing infection rates in men than in women, despite similar rates of drug adherence. Kashuba and her team are the first to explain the mixed clinical trial results by showing that different tissues require more or less of the drug to combat the virus.

The team shows that vaginal, cervical and rectal tissue all respond differently to Truvada. Twice as much of the drug is needed to prevent HIV infection in vaginal and cervical tissue than rectal tissue because fewer components of Truvada make it into those two tissue types. Also, there is more DNA material that the virus uses to reproduce present in vaginal and cervical tissues, thus requiring more of the drug to prevent infection.

"The more DNA material there is available for HIV to work with, the more medicine is needed to block the process," said Mackenzie Cottrell, M.S., Pharm.D., a research assistant professor at the pharmacy school and lead author of the study. "In essence, we calculated the most effective drug-to-DNA ratio for each tissue type."

The UNC-Chapel Hill team used human cells in a test tube to measure how much DNA material was in the cells and how much Truvada was needed to prevent HIV infection in these cells. Then they gave healthy female volunteers Truvada and measured how much of the drug got into vaginal, cervical and rectal tissue, and how much DNA material was there. Using both the test tube and human data, Kashuba and her team created a mathematical model that predicts the drug-to-DNA ratios in vaginal, cervical and rectal tissues and calculates the amount of drug needed to prevent HIV from infecting human tissues.

"We are excited to be able to apply our research methods to explain the conundrum of mixed clinical trial results of Truvada prevention, and how men and women should best use HIV prevention therapy," Kashuba said. "Yet we would like to remind people who are taking pre-exposure prophylaxis that Truvada should be taken every day to reduce the risk of acquiring HIV infection. Patients should not change their medication regimen without first consulting their physicians."

Daily dosing of Truvada was approved in 2012 to help prevent the spread of HIV, and it is the only drug approved by the FDA that has been shown to reduce HIV infection rates.

**Journal Reference:**

[A Translational Pharmacology Approach to Predicting HIV Pre-Exposure Prophylaxis Outcomes in Men and Women Using Tenofovir Disoproxil Fumarate±Emtricitabine](#)

Mackenzie L. Cottrell, Kuo H. Yang, Heather M.A. Prince, Craig Sykes, Nicole White, Stephanie Malone, Evan S. Dellon, Ryan D. Madanick, Nicholas J. Shaheen, Michael G. Hudgens, Jacob Wulff, Kristine B. Patterson, Julie A.E. Nelson and Angela D.M. Kashuba

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

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## 8-Week Long-Acting Injectable HIV Treatment Succeeds, is Moving to Advanced Trials

As reported by POZ | 2.26

A long-acting injectable formulation of ViiV's cabotegravir and Janssen's Edurant (rilpivirine), dosed every four or eight weeks, is safe and generally well tolerated and suppresses HIV as well as a daily oral regimen in an ongoing trial. The companies intend to start Phase III trials of long-acting cabotegravir/Edurant, dosed every eight weeks, later this year. If this research is successful, the treatment will likely hit the market in 2019.

The Phase IIb, ongoing, open-label, parallel group, international multicenter LATTE-2 study of the long-acting injectable formulations of experimental integrase inhibitor cabotegravir and Janssen's non-nucleoside reverse transcriptase inhibitor (NNRTI, or non-nuke) Edurant (rilpivirine) includes 309 treatment-naive participants living with HIV. Results were presented at the 2016 Conference on Retroviruses and Opportunistic Infections (CROI) in Boston.

Top-line results from this trial [were released](#) in November 2015.

Participants were first treated for 20 weeks with daily oral cabotegravir plus two nucleoside reverse transcriptase inhibitors (NRTIs). Then they were randomized into three groups for what was called the study's maintenance period: They received intramuscular injections of Edurant/cabotegravir either every four or eight weeks, or they continued taking the oral regimen.

After 32 weeks of maintenance treatment, the viral suppression rates in the four- and eight-week injection groups and the oral medication group were a respective 94 percent, 95 percent and 91 percent. One participant in the eight-week dosing group and one in the oral drug group developed virologic failure. Neither of them had evidence of drug resistance.

The most commonly reported drug-related adverse health problem among those receiving the injectable drugs was injection site pain (92 percent). Eighty-two percent of these cases were mild, while 17 percent were moderate in severity. Injection site reactions lasted a median of three days, and decreased in frequency after the first dose. Such reactions led two participants (less than 1 percent) to drop out of the trials.

The most commonly reported adverse health problems not related to injection site reactions during the maintenance period were upper respiratory infection (20 percent), headache (14 percent) and diarrhea (12 percent). Six percent of participants receiving the injectable medication experienced a serious adverse health problem, one of which was related to the drug, while 5 percent of those in the oral drug group experienced such a health problem, none of which were drug related.

One person in the eight-week injectable group died from a seizure that was unrelated to the drug. Nine participants dropped out of the study because of adverse health matters. Sixteen percent of those receiving the injectable drug and 14 percent of those on the oral drugs experienced Grade 3 or above lab abnormalities.

Ninety-seven percent of those in the eight-week dosing group and 96 percent of those in the four-week dosing group said at the 32-week point that they were satisfied with their current treatment, compared with 71 percent of those in the oral drug group.

The study will continue through 104 weeks of maintenance treatment.

To read a press release on the study, [click here](#).

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

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## Two-Drug Pill Before and After Sex Prevents HIV Infection in Gay Men

As reported by The Body Pro | 2.25

Taking a pill that combines two antiretrovirals before and after sex lowered the risk of HIV infection by 86% in gay or bisexual men in France and Canada.<sup>1</sup> Taking this tablet before and after sex -- rather than every day as in other studies of this strategy -- could simplify this approach to protecting oneself from HIV infection and could lower the rate of side effects from the antiretrovirals used.

Several research groups around the world have tested PrEP -- which stands for pre-exposure prophylaxis -- with a pill called Truvada that combines two antiretrovirals, tenofovir and emtricitabine (abbreviated TDF/FTC). Only people who have a recent negative HIV test should take PrEP. These studies found that PrEP with TDF/FTC can lower the risk of HIV infection in gay men and other men who have sex with men,<sup>2</sup> in heterosexual HIV-negative people with a steady HIV-positive sex partner,<sup>3,4</sup> and in people who inject drugs.<sup>5</sup> In two studies of heterosexual African women, PrEP did not prevent HIV infection, probably because many women did not take their PrEP pills often enough.<sup>6,7</sup> Trials of successful PrEP also found the highest rates of protection from HIV in people who took their PrEP pills as scheduled.

In all of these previous PrEP trials,<sup>2-7</sup> people tried to take their PrEP pill every day. Researchers working with the French national HIV trials group suggested HIV-negative people would have an easier time taking PrEP pills just before and after having sex with a partner who might have HIV. They decided to test this as-needed PrEP strategy in sexually active gays and other men who have sex with men.

### How the Study Worked

Researchers invited gay men or transgender women who have sex with men to join the study. All participants had to be 18 or older, and all had anal sex without a condom with at least two male partners in the past 6 months. The study did not include anyone with hepatitis B virus or hepatitis C virus infection or anyone with laboratory signals of poor kidney function. Tenofovir (TDF), one of the antiretrovirals in the PrEP pill, can hurt kidney function.

Researchers randomly assigned participants to use the TDF/FTC PrEP pill or a look-alike dummy pill called a placebo. Participants were told to take (1) two PrEP pills (or placebo) 2 to 24 hours before

having sex, (2) one PrEP pill (or placebo) 24 hours after the first two pills, and (3) another PrEP pill (or placebo) 24 hours after that (Figure 1). Participants completed an at-home computer interview about basic personal information (like age and race) and about sexual behavior and use of drugs and alcohol.

Participants made study visits 4 weeks after entering the study, 4 weeks after that, then every 8 weeks. At each visit they received enough PrEP pills (or placebo) for daily use, counseling about taking these pills according to the study plan, free condoms and gel, and a test for HIV-1 and HIV-2 (the two types of HIV). Participants returned study-drug bottles at each visit so researchers could count the pills they had left as a measure of PrEP pill taking. Researchers also measured levels of TDF and FTC in blood of some participants to see whether they had taken PrEP pills. Before every study visit, participants completed a computer interview to report whether they had taken their PrEP pills according to the study plan.

The primary goal of the study was to determine how many participants in the PrEP group and the placebo group became infected with HIV-1 or HIV-2. The study also aimed to compare the safety of taking PrEP pills versus placebo.

### **What the Study Found**

Researchers randomly assigned 199 participants to receive PrEP with TDF/FTC (Truvada) and 201 to receive placebo (the dummy pill). No transgender women enrolled in the study. Median age was similar in the two groups -- 35 in the PrEP group and 34 in the placebo group. About 90% of participants were white, and about three quarters were not members of a gay couple. One quarter of participants had more than 5 alcoholic drinks daily for the past month, and about 45% reported using party drugs. Participants averaged about 8 sex partners in the past 2 months. While 89% of participants lived in France, 11% lived in Montreal.

During the 24-month study period, 94% or more of men in the PrEP group and the placebo group attended each scheduled study visit. Men in the PrEP group took a median of 15 pills monthly, as did men in the placebo group. TDF and FTC levels measured in blood reflected reported PrEP use in the preceding week. The PrEP group did not differ from the placebo group in total number of sex acts in the 4 weeks before each study visit or in the proportion of sex acts involving receptive anal sex without a condom. Similar proportions of men in the PrEP group (41%) and the placebo group (33%) picked up a sexually transmitted infection during the study period.

After men started taking their PrEP pills or placebo, 16 men became infected with HIV: 14 men assigned to take placebo (the dummy pill) and 2 assigned to take TDF/FTC PrEP became infected (Figure 2). Based on those numbers, the researchers calculated new-infection rates of 6.60 per 100 person-years in the placebo group and 0.91 per 100 person-years in the PrEP group. A rate of 0.91 per 100 person-years means about 1 of every 100 people in the PrEP group got infected every year. The new-infection rate in the placebo group was more than 6 times higher. The researchers calculated that men assigned to TDF/FTC PrEP had an 86% lower HIV infection rate than men in the placebo group.

When the researchers looked more closely at the 2 men in the PrEP group who became infected with HIV during the study, they found that one man returned 60 of 60 PrEP pills at study visit pill counts, meaning he never took one of the pills. The other man returned 58 of 60 PrEP pills at study visits, meaning he took only two pills. Neither of these two men had TDF or FTC levels detectable in blood.

None of the men in the PrEP group or the placebo group had any serious medical problems that might be caused by antiretrovirals like TDF or FTC. A higher proportion of men in the PrEP group than the placebo group (14% versus 5%) had minor stomach or bowel problems like nausea, vomiting, or diarrhea.

### **What the Results Mean for You**

This study of 400 men without HIV infection showed that taking two PrEP pills in the 24 hours before sex and two PrEP pills after sex (Figure 1) lowered the risk of HIV infection 86%. Previous studies of PrEP with a pill containing the same two antiretrovirals (TDF/FTC or Truvada) helped protect gay men, heterosexual men and women, and people who inject drugs from getting HIV infection.<sup>2-5</sup> But all of those previous studies required participants to take a PrEP pill every day. The new study required men to take their PrEP pills only before and after sex. Taking PrEP pills only before and after sex could make it easier for PrEP users to take as many pills as they need to protect themselves from HIV infection.

It is important to note that the U.S. Centers for Disease Control and Prevention (CDC) PrEP guidelines specifically state that timing PrEP to sex is not recommended.<sup>8</sup> Whether the CDC will change that advice after reviewing findings from the French study is unknown. The latest CDC guidelines limit PrEP to daily TDF/FTC (Truvada) -- or to daily TDF alone (Viread) for people who inject drugs and heterosexual men and women, but not for gay men and other men who have sex with men.

The CDC recommends that people considering PrEP to prevent HIV infection should get tested for HIV immediately before starting PrEP and every 3 months after starting PrEP. Taking TDF/FTC (Truvada) or TDF (Viread) without other antiretrovirals would be bad for people with HIV infection because those drugs would not control HIV. As a result, HIV resistant to TDF, FTC, and possibly other antiretrovirals could develop. The CDC suggests certain groups of people who might consider PrEP (see "Who Should Consider PrEP?").

Another potential advantage of as-needed PrEP versus every-day PrEP is a lower risk of drug side effects. TDF, one of the two antiretrovirals in the most-tested PrEP pill, can cause kidney or bone problems. CDC PrEP guidelines call for kidney function testing before starting PrEP with TDF/FTC and every 6 months while on PrEP.<sup>8</sup> Tenofovir alafenamide (TAF), an antiretroviral similar to TDF but with a lower side-effect potential, will probably become available in a single pill with FTC. Early studies of TAF-based PrEP have begun.

**View the story and associated graphics online:** [Click here](#)

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## **FDA approves Odefsey for treatment of HIV**

As reported by Healio Infectious Disease News | 3.2

The FDA recently approved Odefsey, a tenofovir alafenamide-based regimen, for the treatment of HIV-1 infection, according to a press release from the drug's manufacturer.

The new regimen contains 200 mg emtricitabine (Gilead Sciences; R), 25 mg Edurant (rilpivirine, Janssen Therapeutics; F) and 25 mg tenofovir alafenamide (Gilead Sciences; TAF), and represents the smallest pill of any single tablet regimen, the release said. It is the second TAF-based regimen approved by the

FDA and is indicated for patients aged 12 years and older with no history of ART and maximum HIV-1 RNA levels of 100,000 copies/mL. R/F/TAF also may be used as a substitute for a stable ART regimen in patients who have been virologically suppressed for at least 6 months.

The approval is based on the results of clinical trials that assessed the safety, efficacy and tolerability of rilpivirine-based therapy administered as R/F/Viread (tenofovir disoproxil fumarate, Gilead Sciences; TDF) and R plus F/TDF, and F/TAF-based therapy administered as Genvoya (elvitegravir/cobicistat/emtricitabine/TAF, Gilead Sciences; E/C/F/TAF) in various HIV-positive populations including treatment-naïve adults and adolescents and virologically suppressed adults with or without mild-to-moderate renal impairment who switched from protease inhibitor-, non-nucleoside reverse-transcriptase inhibitor-, and integrase strand-transfer inhibitor-based regimens. A bioequivalence study demonstrated that R/F/TAF achieved similar drug levels as E/C/F/TAF and F in the blood.

TAF is administered in a lower dose compared with TDF and reduces the amount of tenofovir in the bloodstream by 90%, the release said. Data from clinical trials also demonstrated that TAF improved renal and bone safety vs. TDF.

“As people are living longer with HIV, there is an increasing need to develop new treatments that are tolerable and help address long-term health for patients,” John C. Martin, PhD, chairman and chief executive officer of Gilead Sciences, said in the release. “Odefsey’s safety, efficacy and tolerability profile offers a new treatment option to support the needs of a range of patients and represents Gilead’s commitment to innovation in the field of HIV.”

The new treatment carries a boxed warning alerting health care providers of the risk for lactic acidosis and severe hepatomegaly with steatosis, and the worsening of hepatitis B in coinfecting patients post treatment.

The most common adverse events associated with rilpivirine are depression, insomnia and headaches, according to the release. The most frequent adverse event associated with emtricitabine and TAF is nausea.

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

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## **Odefsey: New HIV Combination Pill Is More Gentle on Bones, Kidneys**

Emily Newman, BETA | 3.1

for the treatment of HIV. Odefsey, by Gilead Sciences, is composed of emtricitabine (200 mg), rilpivirine (25 mg), and tenofovir alafenamide (25 mg).

Odefsey contains the same drugs as Complera, except it replaces disoproxil fumarate (TDF) with tenofovir alafenamide (TAF). TAF is a prodrug of tenofovir that delivers high antiviral efficacy at a much lower dose than TDF. The lower dose of TAF that can be used to treat HIV means that it has a better safety profile—and is easier on the kidneys and bones—than TDF.

“As people are living longer with HIV, there is an increasing need to develop new treatments that are tolerable and help address long-term health for patients,” said John C. Martin, PhD, chairman and chief

executive officer of Gilead Sciences. “Odefsey’s safety, efficacy and tolerability profile offers a new treatment option to support the needs of a range of patients and represents Gilead’s commitment to innovation in the field of HIV.”

Odefsey is approved to treat HIV infection in people age 12 and older with no prior antiretroviral therapy history and viral load less than or equal to 100,000 copies/mL. It is also approved to replace an existing stable ARV regimen in people who are virally suppressed below 50 copies/mL for at least six months with no history of treatment failure.

This is the second TAF-containing once-daily pill approved by the FDA for the treatment of HIV. Genvoya, also developed by Gilead Sciences, was approved by the FDA in November, 2015.

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

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## Meet the Man Who Got HIV While on Daily PrEP

Trenton Straube, POZ | 3.3

Ever since July 2012, when the FDA approved Truvada as PrEP, a pre-exposure prophylaxis to prevent getting HIV, its success rate has been, well, perfect. In fact, not a single person adhering to the daily regimen has ever tested HIV positive—and that includes everyone in clinical trials and studies, and the more than 40,000 people taking Truvada as PrEP in the United States. But PrEP researchers, like most scientists, rarely speak in absolutes and guarantees; they’ve acknowledged that, under rare circumstances, an infection is feasible. Last week, that hypothetical situation became a known reality.

On February 25 at the annual Conference on Retroviruses and Opportunistic Infections (CROI) in Boston, David C. Knox, MD, an HIV specialist at the Maple Leaf Medical Clinic in Toronto, presented data on a patient who, after two years of good PrEP adherence, tested HIV positive (for more on that, read [this article](#) by POZ’s Benjamin Ryan).

In Knox’s presentation, his patient remained anonymous, but many of us in the PrEP and HIV communities had followed his seroconversion story in real time as he posted about it last May in the Facebook group PrEP Facts: Rethinking HIV Prevention and Sex, in which he was an active member. Since then, Joe—as he prefers to be called here—dropped off the discussion boards. I had kept his information and interviewed him earlier this year for a potential POZ feature. At that time, the 44-year-old was excited to put 2015 behind him (more on that later). We chatted about gentrification in Toronto’s “gay village,” and he described himself as a “foreigner” whose family had lived in Kuwait and Denmark before moving to Canada when he was 11, experiences that resulted in his speaking several languages and working as an international flight attendant for 14 years. Now employed at a telecommunications giant, Joe sounded optimistic about his future job prospects and he was devoting energy to the new love of his life: Oliver, a Lhaso Apso-Maltese-Yorkie mix. Importantly, Joe had acclimated to a new HIV regimen, taking his meds each morning, and his viral load had remained undetectable.

We spoke again after his doctor’s CROI presentation, which resulted in Joe’s PrEP failure making international headlines. The following interview is compiled from our conversations and has been edited for length and clarity.

**Let’s start at the beginning: How did you first hear about PrEP?**

In November 2012, my doctor, Malcolm Hedgcock from the Maple Leaf Medical Clinic, which deals primarily with HIV-positive people in Toronto, published an article about PrEP in Outlook, one of the gay rags in Canada. I went to see him, and he said, “You’re the second person to voluntarily want to go on PrEP.” As you know, you have to have an HIV test come back negative, then you can’t do anything risky for three months before you have another HIV test, and if that’s negative you can go on PrEP. So all that happened. I passed all of their tests, and I think I started taking it in February or April 2013.

**Did you have problems with side effects or adherence with the daily regimen?**

My body tolerated it well. And I have an app on my phone called Mind Jogger that reminds you to do things. I programmed it so that between 11 a.m. and 1 p.m., it gives me 10 notifications to take my medication. My logic was that no matter what day it is or where I am, I will be awake between 11 and 1.

**Did you remain on Truvada as a daily prophylaxis, or did you use it, as they say, during “seasons of risk”?**

I was on it the entire time. A lot of people disco dose [take it only during risky periods] because of the cost factor. When I took it, in Canada, Truvada was prescribed off-label as PrEP, but my work benefits covered my medication so, for me, it was not a problem. And to be honest, I don’t believe in disco dosing because I think it’s better to maintain the same level of medication in the bloodstream.

**Did PrEP alter your sexual behavior or attitudes?**

Yes. I became more sexually liberated. It took away the fear. I mean, that’s really one of the reasons why people behave themselves [sexually]. It’s not because of morals or religion or society; it’s just the fear of getting sick—especially the fear of HIV. But once you’re on PrEP you’re more comfortable. You feel safer.

**How would you describe your condom use before PrEP?**

It was off and on, depending on the situation. I’m mostly a bottom, but if I was with someone I felt more at ease with, [we wouldn’t use condoms], but it was serosorting of course [having sex with someone of your same HIV status]. But I would say most of the time, it was with condoms.

**Did PrEP change your condom habits?**

Oh, yes, definitely. To be honest with you, I stopped using condoms after going on PrEP. I was such a big proponent of PrEP that if I was chatting with someone on a hookup site who wanted to use condoms, it was a deal-breaker for me. I was having sex to enjoy it. And if I was wearing a condom or the other person was wearing a condom, I wouldn’t enjoy it.

**When we first spoke, you said that when you started PrEP you were in a relationship with an HIV-negative partner, but after 11 years that ended (the ex remains HIV negative today). You also said that you were taking antidepressants and that this January was one of the few recent months you didn’t end up in the emergency room. What was going on in your life?**

Last year was really horrible. In January, I went snowboarding at Whistler Pride, a big gay ski week. It’s a lot of fun—unless you fall down the mountain and get a concussion like I did. I was off work for about six weeks. When I went back, I started to develop stomach issues and it turned out I had *Helicobacter pylori*, a bacteria that causes stomach ulcers. It exists in about two thirds of the population, usually in people from third-world countries or who have visited third-world countries, so it could have been from my being born in Iraq or being a flight attendant. I went on a course of antibiotics, and that was that. But I was still having stomach problems, so I went in for an endoscopy and colonoscopy, and found out my stomach muscle was getting paralyzed and stuck, something called gastroparesis. Basically, it wouldn’t

digest food. I went on some other medications. Then in April, I broke my pinkie playing dodgeball. Like I said, last year was really horrible.

**How are those conditions today?**

They're fine. I haven't had any relapses.

**This brings us to May 2015. Walk us through the events of your HIV diagnosis.**

Just to backtrack: I knew there was always a possibility of becoming infected on PrEP, but the science was in my favor. And my doctor had changed. Dr. Hedgcock had moved and Dr. David Knox took his place.

On May 4, I had the regular quarterly blood test for HIV and STIs [sexually transmitted infections] and kidney and liver function, and all that. On Friday, May 8, at 6 p.m. my doctor gives me a call at home and says, "Joe, your [p24 antigen](#) came back positive."

I said, "OK, what does that mean?" And he goes, "You're HIV positive." And it was...it was a bit of a shock. I said, "That can't be, there's no way. Are you sure it's not a false positive?" He said that in 90 percent of cases where the p24 antigen comes back positive, the person is HIV infected.

**Subsequent testing confirmed that the infection resulted from a rare strain of HIV that's resistant to multiple HIV meds. But before waiting for those results, you chose to initiate treatment right away, correct?**

I said, let's nip it in the bud. He put me on a very strong course of medication, and within three weeks my viral level disappeared. Now I'm on a different course of HIV medication, just once a day, in the morning.

**To what do you attribute your ability to make it through these challenges? Did you join a support group or anything like that?**

To be honest with you, it's being educated in terms of my situation. The biggest condition I have, the worst condition, is still not fatal—it's managed and controlled. But there's no religion or whatever that I can rely on, so really it's science and facts.

In terms of support groups, I have a strong circle of friends, many who have been living with HIV 20-plus years who I can talk to. But my doctor referred me to an HIV psychiatrist, and because I was on certain antidepressants, I think that helped in terms of calming the waves and not having breakdowns.

To be honest, I don't wake up in the morning and think of myself as an HIV-positive person. Sometimes even when I say it, it's a bit odd because nothing has changed in terms of my life.

**Blood tests pinpointed a timeframe when you contracted HIV. Did you have any interest in figuring out who likely had this virus, or in alerting him about it?**

Here's the story. He's in a relationship and "discreet." We met on bbrt [a bareback community], and he says he's negative. I prefer to be with people who are positive and know it and are on meds—I'm on PrEP, you're undetectable, the chances of transmission are like negative 10 percent—but I broke my rule with this guy. So it was with him, I think—it was a bit of a busy period. I reached out to him and he says, "Well, I'm not worried, I'm OK. But I'll go see a doctor." And I checked in with him again: "Have you gone? What are the results?" "Oh I'm really busy and haven't had a chance." I checked in again. "Oh, I'm out of town on work." Checked again, and he stopped replying to me. To be honest, I gave up. I don't

need to be vindicated or have him say I'm sorry or whatever. I just wanted to let him know. It's being socially responsible.

**And now your case study is making global headlines. Have you been following the press and online discussions?**

Normally, I'm involved, but I try to stay away from the social commentary regarding this announcement. There was someone, a Facebook friend, who made a blanket statement about, "Enjoy your AIDS, PrEPsters." I don't know if it comes from fear or hatred or whatever, but some people feel vindicated that PrEP is not 100 percent. And it's the Internet, right? Everyone's got an opinion. To be honest with you, I've been focused on work; I applied for a new position, and there are a lot of expected changes. It's been good.

**It sounds like you're not letting the diagnosis and media coverage affect your general health.**

Absolutely not. I just got a great blowjob.

**What? Wow. Alright then. There you go.**

A little lunchtime break.

**As a POZ editor, I understand that oral sex is an extremely low-risk, and that your being undetectable pushes it lower still—I even wrote a [story on the topic of HIV risk](#)—but it's a bit surprising to hear you be so upfront about enjoying a little afternoon delight. It's also incredibly refreshing and empowering.** I believe in personal accountability and responsibility for your own health. I'm open and upfront with all sexual partners, from my status to my dislike of condoms. I have my own rules and limitations. I don't impose them on others. If we're not a match, then we're not a match. If you have questions or doubts, I'll answer them. But I won't try to convince or cajole you.

**Why is it important to get this story out?**

Because knowledge is power; the more we know, the better we're prepared. PrEP's a calculated risk. It's important for people to know that there is the possibility as opposed to the fantasy that there have been no recorded infections on PrEP. At least now there is one, so it makes it more real. And I tell people, "It didn't work for me, but I still think it's great." If I had to do it all over again, I would still go on PrEP. I just wouldn't have sex with that specific person.

**Finally, what did you think about the other big PrEP news from this week, that the Canadian government just approved Truvada as PrEP?**

I was relieved. I thought, "Finally. It's approved!" As PrEP becomes more mainstream, there will be more awareness. Doctors will know more. Patients will know more. Many of the myths will be dispelled. And more people will have smart, as well as safe, sex.

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

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## **VA Expands Hepatitis C Drug Treatment**

*Expanded funding now allows VA to provide increased drug therapy at VA facilities nationwide*

U.S. Department of Veterans Affairs, as reported by [blog.aids.gov](#) | 3.11

The Department of Veterans Affairs (VA) today announced that it is now able to fund care for all Veterans with hepatitis C for Fiscal Year 2016 regardless of the stage of the patient's liver disease. The move follows increased funding from Congress along with reduced drug prices.

"We're honored to be able to expand treatment for Veterans who are afflicted with hepatitis C," says VA Under Secretary for Health Dr. David Shulkin. "To manage limited resources previously, we established treatment priority for the sickest patients. Additionally, if Veterans are currently waiting on an appointment for community care through the Choice Program, they can now turn to their local VA facility for this treatment or can elect to continue to receive treatment through the Choice Program."

VA has long led the country in screening for and treating hepatitis C. VA has treated over 76,000 Veterans infected with hepatitis C and approximately 60,000 have been cured. In addition, since the beginning of 2014, more than 42,000 patients have been treated with the new highly effective antivirals. In fiscal year 2015, VA allocated \$696 million for new hepatitis C drugs (17 percent of the VA's total pharmacy budget) and in fiscal year 2016, VA anticipates spending approximately \$1 billion on hepatitis C drugs. VA expects that with the expansion, many more Veterans will be started on hepatitis C treatment every week this fiscal year.

In addition to furnishing clinical care to Veterans with hepatitis C, VA Research continues to expand the knowledge base regarding the disease through scientific studies focused on effective care, screening, and healthcare delivery including to female Veterans and Veterans with complicated medical conditions in addition to hepatitis C.

For additional information on Hepatitis C treatments Veterans can log onto <http://www.hepatitis.va.gov/patient/hcv/index.asp>.

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

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## Canada and Israel OK Truvada as PrEP to Prevent HIV

As reported by POZ | 3.1

Canada and Israel are the latest countries to approve the daily pill Truvada as a pre-exposure prophylaxis (PrEP) to prevent getting HIV. The U.S. FDA gave the green light to Truvada as PrEP in 2012.

When taken daily by HIV-negative people, Truvada is highly effective, reducing the risk of infection by as much as 99 percent. But as [POZ reported](#) last week, researchers have now confirmed one case of a man compliant to PrEP who contracted a strain of HIV that was resistant to the two medications found in Truvada, although such cases are rare.

Canada was late in approving Truvada as PrEP, [according to Vice](#), because Gilead Sciences, which makes the HIV med, didn't apply for approval until last year. Now that it is approved, more people will have access to it through insurance coverage.

There is a demand for PrEP in Canada. Vice reports that about 2,300 people test HIV positive each year. Of the 70,000 HIV-positive Canadians, about half are men who have sex with men (MSM), but aboriginals are also disproportionately affected; they account for a quarter of HIV cases in the country.

Meanwhile, the Health Ministry of Israel also approved Truvada as PrEP, [reports The Jerusalem Post](#). In Israel, PrEP is recommended for MSM who don't use condoms, and heterosexuals who don't use contraception. The Health Ministry will soon decide whether to make the drug available to injection drug users and women at high risk.

Truvada as PrEP has also been approved in Kenya and South Africa, with approvals pending in Australia, Brazil, Peru and Thailand. Gilead is currently [seeking approval from the European Medicines Agency](#), which includes 28 European countries.

For a roundup of POZ's PrEP coverage, click [here](#).

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

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## Scientific Papers/Conference Abstracts

### Saliva use as a lubricant for anal sex is a risk factor for rectal gonorrhoea among men who have sex with men, a new public health message: a cross-sectional survey

Chow EPF, Cornelisse VJ, Read TRH, et al. *Sex Transm Infect* 2016; [Epub ahead of print]

#### Background

Apart from penile–anal intercourse, other anal sexual practices (rimming, fingering and saliva use as a lubricant for anal sex) are common among men who have sex with men (MSM). The aim of this study is to evaluate whether these anal sexual practices are risk factors for rectal gonorrhoea in MSM.

#### Method

A cross-sectional survey was conducted among MSM attending Melbourne Sexual Health Centre between 31 July 2014 and 30 June 2015. Rectal gonorrhoea cases were identified by culture.

#### Results

Among 1312 MSM, 4.3% (n=56) had rectal gonorrhoea. Other anal sexual practices were common among MSM: receptive rimming (70.5%), receptive fingering or penis dipping (84.3%) and using partner's saliva as a lubricant for anal sex (68.5%). Saliva as a lubricant (adjusted OR 2.17; 95% CI 1.00 to 4.71) was significantly associated with rectal gonorrhoea after adjusting for potential confounding factors. Receptive rimming and fingering or penis dipping were not statistically associated with rectal gonorrhoea. The crude population-attributable fraction of rectal gonorrhoea associated with use of partner's saliva as a lubricant for anal sex was 48.9% (7.9% to 71.7%).

#### Conclusions

Saliva use as a lubricant for anal sex is a common sexual practice in MSM, and it may play an important role in gonorrhoea transmission. Almost half of rectal gonorrhoea cases may be eliminated if MSM stopped using partner's saliva for anal sex.

**View the paper online:** [Abstract](#)

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## HIV Incidence Among Men Who Have Sex With Men After Diagnosis With Sexually Transmitted Infections

Katz DA, Dombrowski JC, Bell TR, et al. *Sex Transm Dis* 2016;43(4):249-254

### Background:

Men who have sex with men (MSM) are at high risk for acquiring HIV infection after diagnosis with other sexually transmitted infections (STIs). Identifying the STIs associated with the greatest risk of subsequent HIV infection could help target prevention interventions, particularly preexposure prophylaxis (PrEP).

### Methods:

Using matched HIV and STI surveillance data from Washington State from January 1, 2007, to June 30, 2013, we calculated the incidence of new HIV diagnoses after different STI diagnoses among MSM. Men entered observation at the time of their first STI diagnosis during the study period and exited at HIV diagnosis or June 30, 2013. Cox proportional hazards regression was used to conduct a global comparison of rates.

### Results:

From January 1, 2007, to June 30, 2013, 6577 HIV-negative MSM were diagnosed as having 10,080 bacterial STIs at 8371 unique time points and followed for 17,419 person-years. Two hundred eighty (4.3%) men were subsequently diagnosed as having HIV infection for an overall incidence of 1.6 per 100 person-years (95% confidence interval, 1.4–1.8). The estimated incidence of HIV diagnoses among all MSM in the state was 0.4 per 100 person-years. Men who have sex with men were at the greatest risk for HIV diagnosis after being diagnosed as having rectal gonorrhea (HIV incidence, 4.1 per 100 person-years), followed by early syphilis (2.8), urethral gonorrhea (1.6), rectal chlamydial infection (1.6), pharyngeal gonorrhea (1.1), late syphilis (1.0), and urethral chlamydial infection (0.6;  $P < 0.0001$  overall).

### Conclusions:

Men who have sex with men diagnosed as having rectal gonorrhea and early syphilis were at the greatest risk for being diagnosed as having HIV infection after STI diagnosis. These men should be prioritized for more intensive prevention interventions, including PrEP.

View the paper online: [Abstract](#)

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## Significant Reduction in the Incidence of Genital Warts in Young Men 5 Years Into the Danish Human Papillomavirus Vaccination Program for Girls and Women

Bollerup S, Baldur-Felskov B, Blomberg M, et al. *Sex Transm Dis* 2016;43(4):238-242

### Background:

Denmark introduced the quadrivalent human papillomavirus vaccine into the vaccination program for 12- to 15-year-old girls in 2008 to 2009. In 2012, the program was supplemented with a catch-up program for women aged up to 27 years. We evaluated the effectiveness of the Danish vaccination program on the nationwide incidence of genital warts (GWs), after the second catch-up by including information on both hospital treatments and on self-administered treatment with podophyllotoxin. Genital wart incidence was investigated in both sexes; however, the main focus was on potential herd protection of men.

**Methods:**

Incident cases of GWs were identified from the Danish National Patient Register and through redemptions of prescription for podophyllotoxin in the Danish National Prescription Registry in 2006 to 2013. Age-specific incidence rates (IRs) were assessed, and estimated annual percentage change (EAPC) was calculated by Poisson regression.

**Results:**

Genital wart incidence was either stable or increased in both sexes in 2006 to 2008. After introduction of the vaccination program, GW incidence decreased significantly in women aged 12 to 35 years and men aged 12 to 29 years, with rapid decrease among 16- to 17-year-olds (IRwomen, from 1071 to 58 per 100,000 person-years [EAPC, -55.1%; 95% confidence interval, -58.7 to -51.2]; IRmen, from 365 to 77 per 100,000 person-years [EAPC, -36.6%; 95% confidence interval, -40.5 to -32.5] in 2008–2013).

**Conclusions:**

We found a significantly decreasing incidence of GWs in women up to 35 years of age after the start of the human papillomavirus vaccination program. A similar pattern was observed for men aged 12 to 29 years, indicating substantial herd protection.

View the paper online: [Abstract](#)

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## Screening for Asymptomatic Gonorrhoea and Chlamydia in the Pediatric Emergency Department

Schneider K, FitzGerald M, Byczkowski T, et al. *Sex Transm Dis* 2016;43(4):209-215

**Background:**

Because adolescents rely heavily on emergency services for health care, a pediatric emergency department (PED) visit may be their only opportunity for sexually transmitted infection (STI) screening. The primary objectives of this study were to determine the proportion of *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) infections in asymptomatic PED adolescents and patient-perceived barriers to STI screening.

**Methods:**

A convenience sample of patients aged 14 to 21 years presenting to an urban PED with nongenitourinary complaints was offered screening for GC and CT. Regardless of declining or accepting screening, all were asked to complete a questionnaire designed to identify barriers to screening.

**Results:**

Sixty-eight percent of those approached participated (n = 719). Those who agreed to STI screening were more likely to be nonwhite (61.4% vs. 38.6%, P = 0.001) and publically insured (63.3%) versus privately insured (29.3%) or no insurance (7.58%). Four hundred three (56%) participants provided urine samples, and of those, 40 (9.9%) were positive for an STI. Controlling for other demographics, race was a significant predictor, with the odds of testing positive for nonwhite participants 5.90 times that of white participants. Patients who refused testing were more likely to report not engaging in sexual activity (54.3% vs. 42.4%, P = 0.009) and less likely to perceive that they were at risk for STIs.

**Conclusions:**

There are high proportions of GC and CT among asymptomatic adolescents visiting an academic urban PED. A universal PED STI screening program may be an important component of STI reduction initiatives, especially among adolescents who do not perceive that they are at risk and may not receive testing elsewhere.

View the paper online: [Abstract](#)

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## Exploring Factors Associated with Recent HIV Testing among Heterosexuals at High Risk for HIV Infection Recruited with Venue-based Sampling

Gwadz M, Cleland CM, Jenness SM, et al. *J AIDS Clin Res* 2016; 7:544. doi:10.4172/2155-6113.1000544

### Abstract:

Annual HIV testing is recommended for high-risk populations in the United States, to identify HIV infections early and provide timely linkage to treatment. However, heterosexuals at high risk for HIV, due to their residence in urban areas of high poverty and elevated HIV prevalence, test for HIV less frequently than other risk groups, and late diagnosis of HIV is common. Yet the factors impeding HIV testing in this group, which is predominantly African American/Black and Latino/Hispanic, are poorly understood. The present study addresses this gap. Using a systematic community-based sampling method, venue-based sampling (VBS), we estimate rates of lifetime and recent (past year) HIV testing among high-risk heterosexuals (HRH), and explore a set of putative multi-level barriers to and facilitators of recent testing, by gender. Participants were 338 HRH African American/Black and Latino/Hispanic adults recruited using VBS, who completed a computerized structured assessment battery guided by the Theory of Triadic Influence, comprised of reliable/valid measures on socio-demographic characteristics, HIV testing history, and multi-level barriers to HIV testing. Logistic regression analysis was used to identify factors associated with HIV testing within the past year. Most HRH had tested at least once (94%), and more than half had tested within the past year (58%), but only 37% tested annually. In both men and women, the odds of recent testing were similar and associated with structural factors (better access to testing) and sexually transmitted infection (STI) testing and diagnosis. Thus VBS identified serious gaps in rates of annual HIV testing among HRH. Improvements in access to high-quality HIV testing and leveraging of STI testing are needed to increase the proportion of HRH testing annually for HIV. Such improvements could increase early detection of HIV, improve the long-term health of individuals, and reduce HIV transmission by increasing rates of viral suppression.

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

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## Resources, Webinars, & Announcements

### Release of 2014 School Health Policies and Practices Study (SHPPS) Fact Sheets

March 2016, CDC

Today, the Division of Adolescent and School Health released 11 new fact sheets from the 2014 School Health Policies and Practices Study, available on the

results from either a specific topic or a specific component of the Whole School, Whole Community, Whole Child model.

The release includes fact sheets on:

- Alcohol or other drug use prevention
- Counseling, psychological, and social services
- Health education
- Health services
- HIV prevention
- Integrated pest management
- Physical school environment
- Pregnancy prevention
- STD prevention
- Suicide prevention
- Violence prevention

#### **SHPPS Background:**

SHPPS is a national study periodically conducted to assess school health policies and practices at the state, district, school, and classroom levels. SHPPS was conducted at each of these levels in 1994, 2000, and 2006. In 2012, SHPPS was conducted at the state and district levels. In 2014, SHPPS was conducted at the school and classroom levels. Data collection for 2016, conducted at the district level only, is in progress. Results will be released in 2017.

#### **For more information about SHPPS:**

- Web site: [www.cdc.gov/shpps](http://www.cdc.gov/shpps)
- Phone: 1-800-CDC-INFO (1-800-232-4636)
- E-mail: [nccddashinfo@cdc.gov](mailto:nccddashinfo@cdc.gov)

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### **A New, Easy Way To Order Act Against AIDS Materials**

Act Against AIDS has recently partnered with [CDC-INFO](#) to provide an easy and quick way to order all of your favorite Act Against AIDS campaign materials. To order materials free of charge, [please visit the CDC-INFO on Demand ordering system website](#). From there, you can search for Act Against AIDS materials by choosing the campaign from the “Programs” drop-down menu and then filtering results based on language and type of material.

For any questions or help with using the CDC-INFO on Demand ordering system, please call 800–CDC–INFO (800–232–4636).

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### **Prevention IS Care Launches Third Resource Kit**

The [Prevention IS Care campaign](#) launched its [third resource kit](#) in February 2016. The kit emphasizes retention in care, antiretroviral therapy (ART) adherence, and practicing safer sexual behaviors—all to help protect the health of people living with HIV and to help prevent transmission. The content of each material was tested with HIV care providers and people living with HIV to make certain the content met the informational needs of the audience. The kits contain resources developed for HIV health care providers, resources for use during patient/HIV care provider discussion, and patient-education materials. In addition, the kit includes revised materials that are frequently used by HIV care providers,

such as the Separating Fact From Fiction brochure and the Partner Services Brochure. The resource kit can be ordered through the CDC-INFO on Demand ordering system website or by calling 800–CDC–INFO (800–232–4636). To learn more about the new Prevention IS Care toolkit, please email [ActAgainstAIDS@cdc.gov](mailto:ActAgainstAIDS@cdc.gov).

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## Share Your Experience: Our Stories of Stigma

### The Body

HIV stigma and discrimination are real, painful and persistent forces in the lives of people with HIV. They can also be a major barrier in accessing HIV prevention, treatment or care.

Stigma is borne out of fear, ignorance and prejudice – and many feel it can be overcome with openness and access to information. Legal remedies and advocacy can be used to counter discrimination.

We invite you to share – anonymously or by name – your own stories of facing or overcoming stigma and discrimination. Whether you tackled it fully or still live with the pain of ongoing bias, **we care** and we want you to help tell your truth.

We also invite stories from the partners or family members of people with HIV who may have faced or witnessed stigma or discrimination, as well as those who may have experienced PrEP stigma or other HIV prevention-related stigma or discrimination.

Tell us your story the best way you know how – written (1000 words or less, please), a YouTube video or whatever works for you. Email it to [afung@thebody.com](mailto:afung@thebody.com). It is *always* your choice whether you wish to share your name.

Stay strong, and thank you for sharing your story.

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## Job/Internship Postings

### Public Health Nurse - Communicable Disease Program, San Mateo County Health System

**Organization:** San Mateo County Health System, Communicable Disease Program  
**Location:** San Mateo County, CA  
**Salary:** \$51.69 - \$61.10 Hourly  
**App. Deadline:** April 4

The San Mateo County Health System is seeking an experienced and qualified **Public Health Nurse (PHN)** to serve in the **Communicable Disease Control Program**. The mission of the Communicable Disease Control Program is to protect and promote the health of all San Mateo County residents through surveillance, investigation, prevention, and control of communicable diseases of public health significance, excluding tuberculosis and sexually transmitted diseases which are addressed by separate

programs.

Under the administrative supervision of the Community Program Supervisor and clinical supervision by the Communicable Disease Controller, the PHN will coordinate and provide disease control and prevention services to patients, case contacts, health care providers, institutions, organizations, and the community. These activities include, but are not limited to, epidemiological surveillance, case/contact and outbreak investigation and follow-up, provision of clinical services and immunizations, participation in development of communicable disease preparedness and control protocols and policies, and formulation of education, training, and written materials regarding communicable diseases.

The PHN will serve as an internal resource for communicable disease issues, as well serve as a resource to our external collaborative partners, such as health care providers, institutions, organizations, the public, and the community at large. These responsibilities include providing clinical perspective and guidance to personnel performing disease investigations.

Due to the nature of the Communicable Disease Control specialty, the PHN may be required to work during evenings, weekends, and holidays. The ability to independently conduct field investigations in a wide range of settings with individuals from diverse cultural and socioeconomic backgrounds is vital. The position also requires sound critical thinking and decision-making skills, clinical and technical expertise, as well as excellent interpersonal and communication skills.

The **ideal candidate** will have a background in Public Health Nursing, preferably with experience applying tools and strategies to control the spread of infectious diseases. The ideal candidate will also have a strong understanding of Title 17, California Code of Regulations §2500, experience conducting case and outbreak investigations, and experience presenting public health messages to community stakeholders.

#### **Example of Duties:**

Duties may include, but are not limited to, the following:

- Investigate reportable communicable diseases as mandated by Title 17, California Code of Regulations §2500.
- Assist with outbreak investigations.
- Participate in on-call weekend PHN shift rotations providing consultation and guidance to providers and facilities reporting communicable diseases and outbreaks, and responding to inquiries after consultation with on-call Weekend Health Officer.
- Screen Confidential Morbidity Reports, lab reports and other information regarding communicable diseases received via fax, phone or electronically through the State of California CalREDIE system.
- Prepare informational bulletins, exposure notices, health advisories and alerts, public meetings and other appropriate means to inform local medical providers, affected populations, community organizations, and the general public of relevant disease trends and outbreaks in a timely manner.
- Collaborate with the Epidemiology Unit in order to assess communicable disease trends and the need for increased surveillance, investigation, or other appropriate intervention.
- Provide guidance and support to Communicable Disease Investigator (CDI) staff members involved in communicable disease investigations.
- Maintain collaborations with other local health jurisdictions, agencies, and Health System divisions.
- Assist with out-of-jurisdiction communicable disease reporting to the appropriate jurisdiction.
- Participate in Officer of the Day phone consultation duties, fielding inquiries from health care providers, partners and the general public.

- Provide and coordinate a wide variety of disease control and prevention services to patients, case contacts, health care providers, institutions, organizations and communities throughout San Mateo County. This includes case and contact assessment, along with screening that may involve specimen collection (e.g., venipuncture, nasopharyngeal swab, stool specimen).
- Provide and participate in communicable disease education, presentations, and in-services to professional and lay groups within the community upon request, when feasible.
- Participate in the development and maintenance of communicable disease information for staff, providers, institutions, organizations, communities, and the general public.
- Assist with orientation of new staff, students, interns, and preceptees to communicable disease control programs and activities.
- Perform related duties as assigned.

**Qualifications:**

**Education and Experience:** Any combination of education and experience that would likely provide the required knowledge, skills, and abilities is qualifying.

**Licensure/Certification:**

- **California license as a Registered Nurse**
- **California Public Health Nurse Certification**

**Knowledge of:** Principles and practices of public health nursing, with emphasis on field and clinic activities; problem solving through nursing process; technical nursing procedures; health and social services resources; and collaborative health planning with multi-disciplinary teams.

**Skill/Ability to:** Teach and counsel; perform technical nursing procedures; assess physical, psycho-social, and nutritional needs; assess community health needs; teach and guide other health personnel and volunteers; motivate people in positive health attitudes and behavior; work effectively with multi-problem families; problem solve; make independent judgments and ability to work autonomously; assume a leadership role in community health programs; communicate effectively both verbally and orally; be culturally sensitive; be flexible to adapting to a changing environment; and organize communities regarding health matters.

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

**Aaron Kavanaugh**

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Archives of previous STD Updates can be found [here](#). To unsubscribe or add colleagues' names, email [aaron.kavanaugh@cdphc.a.gov](mailto:aaron.kavanaugh@cdphc.a.gov). If you have an item related to STD/HIV prevention which you would like included, please send. No bibliographic questions please; all materials are compiled from outside sources and links are provided. No endorsement should be implied! Note: Some words may have been palced in [brackets] or replaced with blanks (\_\_\_) or asterisks (\*) in order to avoid filtering by email inboxes.

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