

[STD Update] FYI 3-3: San Diego County moving forward with HIV plan, STI test can detect chlamydia in 30 minutes, condom use in French PrEP trial, 5 papers, 1 webinar, 3 jobs, more.

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*STI/HIV Social Worker – San Mateo County Public Health, STI Program*

*STD/HIV Service Integration Unit Chief – CDPH STDCB*

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## **California Stories**

### **San Diego County moving forward with HIV plan**

*Program includes more outreach, more testing, and better access to anti-HIV medicine*

Joshua Steward, The San Diego Union-Tribune | 3.1

While there has been a significant drop in the number of residents contracting HIV, San Diego County is poised to start a program that will encourage county-wide testing, preventative drug prescriptions, and other measures aimed at further cutting the prevalence of the illness.

The effort comes as statistics show that even though HIV is less of a problem today than it was three decades ago, San Diego County still lags behind the state and country in key measures related to combating HIV and AIDS.

At Tuesday's board meeting, county supervisors unanimously approved a measure that aims to stop transmission of HIV and to increase access to treatment for people who have the virus.

"Our goal is to get this disease under control, and minimize it for those who have it, and to prevent the spread of disease to those who do not," Chairman Ron Roberts said. He and Supervisor Dave Roberts introduced the item.

Supervisor Dianne Jacob was the only critic, though said she approved of the effort and its goals. But she voiced concern that a proposal to test every county resident, including adolescents, for HIV isn't cost-effective. She said that it would be more efficient to screen people at high risk of contracting the virus, and that some parents would not want their children tested.

"Why test all three million people in our region? I don't think that's necessary. It certainly would not be cost-effective," Jacob said. "The focus should be on high-risk individuals and I think we can identify those."

An estimated 20,000 people in San Diego county have HIV, and approximately 2,300 are said to be unaware they have the virus. They, along with another 6,400 who have been diagnosed with HIV, are not receiving related care, according to officials.

"About 9,000 of them don't know it or are not in care. Either way, that makes the spread of the disease that more likely," said San Diego City Councilman Todd Gloria, a member of a regional HIV task force.

Diagnoses are declining. In 1990, 1,314 new cases were identified in San Diego County, a number that would drop to 478 by 2013, a task force report says. Deaths from the disease also have dropped from 749 in 1994 to 101 in 2013.

"So much has happened in this battle and the opportunities are truly endless now," Dave Roberts said.

While the statistics show that the problem is not as severe as it once was, San Diego County trails the state and nation in key figures. Around 37 percent of people with HIV follow with their care plan, lower than the approximately 43 percent of patients in California, and 50 percent of patients nationally.

Additionally, just over 40 percent of county patients and patients across the nation have achieved "viral suppression" compared to approximately 43 percent of patients statewide. Viral suppression is a condition where HIV is suppressed and the disease's progression is halted, and the likelihood of transmitting the virus to another person is diminished.

Tuesday's vote gives county staff 120 days to develop a plan to enact a series of recommendations that were included in an August report by the task force.

The recommendations generally take two approaches. One tack connects people with information, be it basic details about screening sites and care clinics to details about antiretroviral drugs. The other focuses on intervention with people who are at high risk of contracting HIV and getting people who have already have the virus to begin a regimen of drugs that can stop its progression and reduce the chances of transmitting HIV to another person.

“When I tell people that there are drugs available, they look at me like they don’t know what I am talking about,” Dave Roberts said.

The report included six major recommendations, including:

- Launch a media campaign to provide general information about the virus, as well as information targeted to reach high-risk people
- Encourage health care providers to make HIV screenings a default part of their medical tests; patients would be tested for HIV unless they opt out.
- Develop a plan to help high-risk people who do not have HIV to start and continue a regimen of medicines that can prevent them from contracting a disease. Likewise, people who might have been exposed should have access to drugs that can prevent the virus from taking hold.
- Create a system to find people who are HIV positive but not receiving care and to get them to start a treatment program.
- Establish a targeted and “culturally appropriate” approach to help populations who are disproportionately impacted by HIV. This should include outreach to young African American and Latinos, and African American and Latino men who have sex with other men.
- Set an overarching policy where the county along with its programs and partners essentially ends the HIV in county over the next decade. Hence the thematic name of the program, “Getting to Zero.”

“We believe the spread of HIV disease can be stopped in San Diego County,” said Terry Cunningham, the chairman of the county HIV Health Services Planning Council.

If the county is able to halt the spread of the virus it will be the first major metropolitan area to do so, he said.

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

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## **Kern County disbands AIDS advisory board**

Madelyn Janssen, Kern Golden Empire | 3.1

Kern County Supervisors voted Tuesday morning to disband the county's AIDS advisory board and replace it with an STD prevention task force.

Public health officials point out that HIV and AIDS aren't the only sexually transmitted diseases impacting communities in Kern County.

In fact, in 2014, Kern County had the highest rate of chlamydia, the highest rate of gonorrhea, and fourth highest rate for syphilis out of all California counties.

The STD prevention task force will expand the work of the AIDS advisory board by developing collaborative and innovative approaches to reduce local STD rates.

"The department has been hard at work understanding how these skyrocketing STD rates impact our community, we have been talking with others throughout the state and other counties that have some progressive actions in place, looked at proven successful strategies, meeting with state department of health and state non-profits and exploring proven evidence-based approaches that we believe can work in Kern county," said Matt Constantine, public health director.

This new board is part of the new approach to tackle our STD problem being taken by the public health department.

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

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## National Stories

### **CROI Roundup: All the HIV News That's Fit to Print**

*A review of all of the big HIV science revelations coming out of the 2016 Conference on Retroviruses and Opportunistic Infections, including the PrEP failure case.*

Benjamin Ryan, POZ | 3.2

Imagine 4,000 major stakeholders in the HIV movement gathered in a convention space for one purpose: to combat the epidemic. The sheer volume of attendance at the annual Conference on Retroviruses and Opportunistic Infections (CROI), held this year in Boston from February 22 to 25, is an awesome testament to how many brilliant and devoted scientists, nonprofit leaders, activists and, yes, even journalists, hailing from the four corners of the globe, have devoted their lives to the HIV cause.

This summary of major scientific presentations at CROI offers a glimpse into the future of the epidemic, which will likely include safer, easier-to-take treatments for the virus, expanded options for pre-exposure prophylaxis (PrEP), and, ultimately, success in getting more people on HIV treatment, thereby curbing the spread of the virus.

For more details about any of the studies, click the hyperlinks.

#### **The first documented case of PrEP failure:**

Since POZ broke the story on February 25, the general public has stirred itself into a clamor over the news of [a Canadian man who contracted multi-drug resistant](#) HIV while apparently adhering well to the daily Truvada (tenofovir/emtricitabine) as PrEP regimen.

A considerable portion of the online chatter over this case is divided into two camps: Those crowing “I told you so,” using the news of PrEP’s failure as supporting evidence for ongoing efforts to denigrate PrEP, discourage its use, and promote condom use instead; and those who have stressed that this case is rare. At times, members of the PrEP-promoting camp take pains to denigrate and discourage condom use. Lost in this polarized debate is the notion that there is often an overlap between PrEP and condom use.

The effectiveness of either HIV prevention method aside, a major question remaining is how evidence of PrEP’s potential for failure, however slight the overall risk of such an outcome, may affect the anxieties of individuals who count on Truvada to keep them protected from HIV.

It is indeed rare to find strains of HIV that are so resistant to both drugs in Truvada that PrEP will not protect against such strains; far less than 1 percent of HIV strains likely fit this category. However, there is also [evidence that resistance to the tenofovir component of Truvada is increasing](#).

More than 9,000 people participated in clinical trials of PrEP and an estimated 40,000 Americans are currently taking it. So the two years the Canadian man spent on PrEP is but a tiny fraction of the tens of thousands of years all HIV-negative individuals have cumulatively spent taking Truvada for prevention thus far. However, it’s still possible that there have been other similar cases of PrEP failure. The Canadian man had a highly proactive physician, who was savvy enough to recognize the potential that he was seeing a PrEP failure case once the man tested positive for HIV, and who was hasty enough to conduct the tests necessarily to provide evidence that would support this suspicion before too much time had elapsed. Others taking Truvada for HIV prevention may also have failed on PrEP, but slipped under the radar because they lacked a physician with such a keen eye and scientific know-how.

### **Antiretrovirals of the future: PrEP 2.0 and long-acting HIV treatment:**

The PrEP science presentations that apparently excited CROI attendees the most concerned two large trials examining the effectiveness of an antiretroviral-containing vaginal ring as PrEP among sub-Saharan African women. The ring was only partially effective in both trials, but worked much better in older women for reasons that are unclear. The ring reduced HIV risk by more than half among women older than 21 in one study.

While these results may seem modest, they were met with marked enthusiasm by the CROI attendees; both researcher presenters received fervent applause as well as standing ovations from some in the audience.

CROI saw several reports of other upcoming versions of PrEP, suggesting that Truvada may have company one day (although probably not until 2020—check out POZ’s [December 2015 feature on PrEP 2.0 development](#)).

The antiretroviral (ARV) [Selzentry \(maraviroc\) performed well](#) in comparison to the components of Truvada in a Phase II safety and tolerability study. Researchers are in talks to start a large Phase III trial, one that won’t wrap up for several more years.

In another Phase II study, transgender women and men who have sex with men (MSM) adhered well to a [tenofovir-containing rectal PrEP gel](#).

Research into long-acting injectable ARVs, for use as PrEP as well as HIV treatment, is advancing. In a Phase IIa trial, researchers examined a [long-acting injectable version of ViiV Healthcare’s investigative antiretroviral cabotegravir as PrEP](#). Given every 12 weeks, the drug proved safe in most participants, although researchers concluded that future studies need to narrow the dosing frequency to every eight weeks. The goal is to bring this version of PrEP to market in 2020.

Meanwhile, a [Phase IIb trial](#) of injections of [long-acting cabotegravir and Janssen’s non-nucleoside reverse transcriptase inhibitor \(NNRTI, or non-nuke\) Edurant \(rilpivirine\), given every eight weeks as HIV treatment](#), proved safe and generally well tolerated and also suppressed the virus as well as a daily oral regimen in an ongoing trial. The combination will move into phase III trials later this year, with a goal for approval in 2019.

Gilead Sciences is set to receive word in April from the U.S. Food and Drug Administration (FDA) about its application for approval of a new version of Truvada that includes a safer version of the tenofovir component known as TAF. [Research has shown](#) that TAF is safer for the bones and kidneys.

Consequently, many people are wondering whether TAF-inclusive Truvada (which will receive a new name if approved) will ever be approved as PrEP. Researchers will have to conduct the series of clinical trials of the new tablet that are necessary for the FDA to green light it as PrEP, a process that would take many years. For now, research is only in the very early stages.

One study presented at BCROI found that TAF-inclusive Truvada protected monkeys from rectal exposures of the simian version of HIV, SHIV, and did so as well as standard Truvada had in a previous study. However, a small trial of TAF among HIV-negative women raised doubts about whether TAF-inclusive Truvada will lead to high enough drug levels in both vaginal and rectal tissues to protect against HIV as well as standard Truvada. (Researchers believe the findings in this study may apply to men where anal sex is concerned.)

#### **Side effects: of PrEP, as well as of tenofovir among people with HIV:**

Research presented at the conference showed that, among HIV-negative transgender women and MSM, [the first 12 weeks of Truvada led to a modest initial drop in kidney function, one that stabilized thereafter](#). Previous research has shown that such a reduction in kidney function tends to reverse after an HIV-negative person goes off Truvada—which is always an option for anyone taking the drug as PrEP whose regular tests indicate worrisome results where the kidneys are concerned.

[Another study](#) found that, among young adult MSM and trans women on PrEP, the typically small drop in bone mineral density that tends to result from the tenofovir component in Truvada reversed after they stopped taking the drug.

Among HIV-positive people, the use of the traditional version of tenofovir, known as TDF, raises the risk of fractures, according to a large new study. This finding doesn’t necessarily apply to HIV-negative people taking Truvada. HIV itself may contribute to the increased risk of fractures among positive people taking tenofovir. Also, in clinical trials of PrEP, tenofovir was not associated with the risk of broken bones. However, thus far there is no safety data available about the long-term use of Truvada—longer than about two years—among HIV-negative individuals.

#### **The ability of PrEP, as well as HIV testing and treatment, to curb the epidemic:**

[The Centers for Disease Control and Prevention \(CDC\) estimated](#) that [expanding HIV treatment and testing, as well as PrEP, could slash the rate of new U.S. cases of the virus by 70 percent](#) during the next five years. Some good news on this front is that, after years of gloom and doom where U.S. viral suppression rates are concerned, the CDC estimates that [an increasing proportion of Americans living with HIV have an undetectable viral load](#), and therefore are very unlikely to transmit the virus to others.

The CDC contrasted these hopeful glimpses into the future with a dire prediction of the current risk of HIV among certain populations. [The agency projected](#) that half of all black MSM and one in four Latino MSM will contract HIV in their lifetimes if current trends continue.

Despite all of the talk in recent years about HIV treatment's power to reduce the spread of the virus, [research shows](#) that [people taking antiretrovirals are greatly overestimating their own infectiousness](#).

A hopeful sign of Truvada's potential for success in helping to curb the HIV epidemic is a new study in which [a targeted intervention was successful at getting black MSM interested in and adhering to PrEP](#). Previous research has raised questions about whether this population, which is disproportionately affected by HIV to a vast and troubling extent, will ultimately reap the benefits of PrEP.

#### **Half-yearly STI screenings for those on PrEP isn't enough:**

One final bit of PrEP news out of the conference came from research suggesting that [the current CDC guidelines for sexually transmitted infection \(STI\) testing among those on PrEP are insufficient](#). Currently, the CDC recommends testing people on PrEP for STIs twice yearly or in the event of symptoms. CROI saw an emphatic call for changing these guidelines so that they recommend comprehensive STI tests at every one of the quarterly clinic visits required to maintain a PrEP prescription.

#### **The benefits of HIV treatment, more work to do:**

The average life expectancy of people treated for HIV has jumped 14 years during the combination ARV treatment era, but HIV-positive people still have a major gap in this department compared with their HIV-negative counterparts. This deficit narrows considerably if people have more than 500 CD4s, don't have hepatitis B or C viruses (HBV/HCV), don't abuse substances, and are non-smokers.

Meanwhile, [treating HIV early, according to a substudy of the global START trial, reduces the risk of virus-related cancers](#), including cervical and anal cancers, cancers of the head and throat, Kaposi's sarcoma, and Hodgkin and non-Hodgkin lymphoma.

Finally, there is [hopeful news](#) that the World Health Organization's "90-90-90" call for high HIV diagnosis, treatment, and viral suppression rates was not just a pie-in-the-sky goal. WHO encourages nations to reach the following targets by 2020: diagnose 90 percent of their HIV population, get 90 percent of that group on treatment, and get 90 percent of that group virally suppressed, for an overall viral suppression rate of 73 percent. [Botswana's current figures are an impressive 83-87-96](#), vastly besting that infamous laggard, the United States.

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

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## Groundbreaking STI test can detect chlamydia in 30 minutes

As reported by The Telegraph | 2.17

A new device promises to detect the sexually transmitted infection (STI) chlamydia within half an hour.

The Atlas io system was created by the University of Bath's spin-off biotech company Atlas Genetics in 2005. It has now won approval from the EU to be sold.

The development means that patients can be tested and treated for the disease within a single clinic visit.

Chlamydia is one of the most common STIs in the UK - in 2013, more than 200,000 people in England tested positive for it.

If left untreated it can lead to long-term health problems such as infertility, pelvic inflammatory disease and can even trigger reactive arthritis.

The World Health Organisation estimates that 499 million new STIs occur each year, but experts claim this new tool could help win the fight against the spread of such diseases.

Professor Chris Frost, the head of Bath University's chemistry department - and whose research was used to help create the test - explained: "To prevent the spread of infectious diseases, especially sexually transmitted infections, it's very important to get a fast, easy diagnosis that can be given at the first appointment with a patient, allowing treatment to begin quickly before the patient leaves."

The io system works by using DNA probes to accurately detect for infectious diseases speedily.

It's essentially a speeded-up version of the way samples are currently tested through labs, which can typically take three to 10 days.

John Clarkson, CEO of Atlas Genetics, said: "STIs are on the rise and the faster a diagnosis can be made, the faster treatment can be given, not only benefiting the patient but also saving time and money. We believe that our io platform will play a key role in the future of STI diagnosis."

The chlamydia test is the first in a series to be launched on the platform, including screening for gonorrhoea, trichomonas vaginalis and other STIs. It will operate across both the European and US markets.

While Atlas is initially focusing on sexual health, the io platform can be applied to a wide range of infectious diseases.

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

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## Study does not support routine HPV quadrivalent vaccination to protect against anal cancer in older people living with HIV

*Hint of protection against oral HPV infection should encourage further studies on oral cancer prevention, say investigators*

Keith Alcorn, aidsmap | 2.29

The quadrivalent HPV vaccine Gardasil does not protect older adults with HIV against persistent anal infection with human papillomavirus (HPV) or the development of HSIL, but the ACTG A5298 study showed some evidence that it may protect against persistent oral infection, Timothy Wilkin of Weill Cornell Medical College told the Conference on Retroviruses and Opportunistic Infections (CROI 2016) in Boston on Thursday.

Anal cancer caused by HPV is one of the most common cancers with an infectious cause in people living with HIV. Persistent HPV infection with a cancer-causing virus type may lead to the development of HSIL – high-grade squamous intraepithelial lesions (pre-cancerous lesions) and, potentially, to the development of anal cancer.

There is a high prevalence of HSIL in people with HIV, although there is also evidence that lesions frequently resolve without treatment.

Vaccination before becoming sexually active, or before acquisition of cancer-associated types of HPV, is the most effective strategy for the prevention of cervical and anal cancers.

The original Gardasil vaccine, offers protection against the two most common HPV types associated with the development of cervical and anal cancer – HPV types 16, and 18 – as well as HPV 6 and 11 which cause genital warts. The vaccine is routinely offered to girls and boys aged 11-12 and is recommended for young women up to age 26 and young men up to age 21 in the United States, as well as young gay or HIV-positive men age 13-26 who were not vaccinated when they were younger. A newer version of Gardasil protects against 9 HPV types. The vaccine has also been recommended for use in England for men who have sex with men under the age of 45 attending sexual health clinics.

The incidence of anal HPV is high among sexually active gay men: a US cohort study which followed men for at least two years found an annual incidence of 13%.

However, evidence is lacking regarding the efficacy of the HPV vaccine in older people living with HIV, who are more likely to have been exposed to cancer-causing HPV types in the past.

ACTG A5298 was a randomised placebo-controlled study of the quadrivalent HPV vaccine in people living with HIV over the age of 26. The study was designed to test the efficacy of the quadrivalent vaccine in preventing persistent HPV infection and HSIL in adults. Participants were followed for three years.

The study recruited 575 participants with a median age of 47 years, 80% male, 46% white non-Hispanic, 20% Hispanic and 34% black non-Hispanic. The median baseline CD4 cell count was 602 cells/mm<sup>3</sup> and 90% had undetectable viral load (<200 copies/ml). The study excluded participants with anal cancer.

The study population had a high prevalence of anal cytological abnormalities. At baseline, 64% had abnormal anal cytology and 33% had HSIL. Sixty per cent had one or more of the HPV types covered by the quadrivalent vaccine, most commonly HPV 16 (32%), and 11% had oral infection with one or more HPV types covered by the vaccine.

Study participants were randomised to receive quadrivalent vaccine or placebo at baseline, and at weeks 8 and 24. They were tested for HPV DNA in anal and oral tissue and underwent histological screening for HSIL at baseline and every six months thereafter.

Inadequate or non-existent antibody response to HPV infection leads to persistent infection, increasing the risk of pre-cancerous lesions and the development of anal cancer. The efficacy of the vaccine to stimulate antibody responses in people with compromised immunity is therefore critical. The vaccine was highly immunogenic: 99% of participants who received the vaccine had antibodies to HPV 16 at week 24 compared to 48% at baseline. There was no change in HPV 16 seropositivity in the placebo group. No grade 3 or 4 serious adverse events were reported during the study.

After 130 weeks of follow up, there was no significant difference between the two study arms in the number of participants with detectable HPV at any single visit (26 in the vaccine arm vs 33 in the placebo arm, hazard ratio 0.75, 95% CI 0.45-1.26), nor a significant difference in the number of participants with persistently detectable anal HPV (13 vs 17, HR 0.73, 95% CI 0.69-1.44). Although persistent HPV 16 infection declined in the vaccine group by week 130 and returned to above baseline levels in the placebo group, this difference was not statistically significant.

Anal HSIL was detectable after week 52 in 46 of the vaccine recipients and 47 of the placebo recipients (HR 1.0, 95% CI 0.69-1.44). There was no difference in abnormal anal cytology at weeks 52, 104 or 156.

Although there was no significant difference in detection of oral HPV infection at any single visit (7 vs 10, HR 0.68, 95% CI 0.26-1.80), the study found a significantly reduced risk of persistent oral HPV infection in the vaccinated group (1 vs 8, HR 0.12, 95% CI 0.02-0.98,  $p = 0.019$ ).

Why did the vaccine not protect against anal HPV infection or HSIL development? Poor immunogenicity was not the reason, and early infections prior to completion of the full vaccination schedule cannot be blamed, because similar results were found when infections detected prior to week 28 were excluded from the analysis. Instead, say investigators, vaccination likely failed to show a benefit because some prior infections were not detected by anal HPV DNA testing, and because the vaccine does not stimulate cellular immunity to clear pre-existing infections.

The investigators concluded that the study results do not support routine HPV vaccination of adults aged 27 and over for prevention of HPV infection or improvement of HSIL, but do consider the findings regarding prevention of persistent oral HPV infection to justify further investigation of vaccination in people living with HIV for prevention of oral cancers. HPV vaccination has been shown to protect against oral HPV infection in women aged 18 to 25.

One question not addressed in post-presentation discussion was the breadth of the vaccine. The quadrivalent vaccine protects against four types of HPV most commonly associated with cancer, but since this trial began vaccinating participants, the US Food and Drug Administration (FDA) has approved a vaccine to protect against nine subtypes (Gardasil 9) – those included in the previous Gardasil vaccine,

plus types 31, 33, 45, 52 and 58. Whether greater vaccine breadth would have altered the risk of HSIL in this study is unclear.

#### **Reference**

Wilkin TJ et al. *ACTG A5298: A phase 3 trial of the quadrivalent HPV vaccine in older HIV+ adults*. Conference on Retroviruses and Opportunistic Infections, Boston, abstract 161, 2016.

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

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

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

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## **Condom use in French PrEP trial: half only used PrEP, a quarter used condoms and PrEP, one in six used neither**

Gus Cairns, aidsmap | 2.26

An analysis of condom use in the placebo-controlled phase of the French IPERGAY trial of intermittent pre-exposure prophylaxis (PrEP), presented at the Conference on Retroviruses and Opportunistic Infections (CROI 2016), found that just over half of the participants had high levels of PrEP use but rarely used condoms, and about a quarter were “belt-and-braces” users who had high levels of both PrEP and condom use.

However, this left about one in six trial participants who had low levels of use of both PrEP and condoms. While their condom use did not change, in a minority of this group their PrEP use declined significantly during the study.

In this randomised phase of the study, participants did not know if they were taking PrEP or placebo. A second presentation of results from the open-label phase of the study, when all participants knew they were on PrEP, found that the use of condoms where the participant was the receptive partner declined slightly but significantly, with a relative fall from previous condom use rates of about 15 to 20%.

#### **About IPERGAY**

The IPERGAY trial of intermittent PrEP stopped its randomised phase in October 2014 and at the subsequent CROI in February 2015 it was announced that there were 86% fewer HIV infections in the group of participants allocated to PrEP than to placebo. Its full results were published in December 2015.

Details can be found in these linked reports but, in brief, the innovative regimen that IPERGAY offered participants was that they take two tenofovir/emtricitabine (Truvada) pills in the 24 hours before they anticipated having sex, and if they did have sex, then to continue daily PrEP if they continued sex, and to take one pill on both of the two days after sex if they stopped having it.

The presentation on PrEP and condom use confirms that PrEP use as measured by pharmacy refills and returned bottles was generally high. Adherence, defined as the proportion of cases of anal sex covered by at least the double dose beforehand, two doses afterwards, or both, was also high.

#### **PrEP and condom use in the placebo-controlled trial**

The researchers, further analysing the data, discovered that participants fell into four fairly distinct patterns of PrEP use.

Nearly 40% of trial participants were consistent users who used PrEP 95 to 100% of the time they had sex. In fact after the third month of the trial, usage was 100% in this group.

Slightly over 30% of users were high-level but inconsistent users. Their coverage of sex with PrEP varied between 70 and 90% over the course of the trial but did not significantly increase or decline over time. While one reason for this variation could have been poor adherence, another could be that they changed their PrEP status according to the known or perceived HIV or viral load status of partners.

Another group, forming 16% of participants, only used PrEP to cover sex occasionally. During the first 16 months of the trial, their PrEP use fell from about 20% to zero, rallying slightly in the last eight months, though numbers of participants were small by this time and these changes were not statistically significant.

In the smallest of the four groups, forming 13% of participants, PrEP use declined significantly during the trial. These participants started off with 90% use on average in the first two months but usage had fallen to 50% by month ten. It rallied slightly at their one-year visit but had fallen to pretty much zero by month 16.

As for condom use, participants fell into two groups. A majority – 70% – were low-level users whose use of condoms during anal sex varied between 10 and 25% during the trial. The remaining 30% were higher-level users, though on average their condom adherence varied between 80 and 45%, so this is a relative term. Their adherence had a tendency to fall during the trial, from 78% at month one to 45% at month 18, though it increased to 71% at month 24.

Combining the figures for PrEP and condom use, the researchers found that:

##54% of trial participants were consistent or high-level users of PrEP but did not often use condoms

##23.5% had high levels of both PrEP and condom use

##6.5% had high levels of condom use but used PrEP only rarely

##16% rarely used either PrEP or condoms.

It is of course this latter group who are of greatest concern. If compared to the most-protected 23.5%, this group included older participants (50% more likely to belong to this group for every ten years older). They were also twice as likely to not have had college education, twice as likely to say they were dissatisfied with their sex lives and – worryingly – were nearly three times more likely to have had sex with partners they did not know. They were also somewhat more likely ( $p = 0.08$ ) to be the active partners in anal sex.

Qualitative studies from IPERGAY will elucidate further why individuals chose particular PrEP and condom use strategies.

### **Data from the open-label trial**

Another presentation gave data from the open-label phase of the trial when, from November 2014, all participants were given the option to use Truvada PrEP.

Among the 400 participants initially enrolled in IPERGAY, 336 were eligible to join the open-label study (the remainder having dropped out of the study for various reasons) and all but three joined. Another 29 new participants were enrolled, making 362. All but one transgender woman were gay men.

The data shown at this conference were for the ten months up to the end of September 2015 and the cumulative follow-up time was 248 participant-years. Study retention was good with only 13 participants discontinuing follow-up (3.6%).

Their average age was 35, and 84% were of French or European origin. At the start of the open-label phase, 10% had had no anal intercourse in the previous month and the average number of partners in the previous two months was seven.

During the open-label phase, one person became HIV positive. Like the two people allocated to PrEP who acquired HIV during the randomised phase, he had stopped using PrEP. He was in the randomised trial for eight months and was diagnosed one month and ten days into the open-label study. By self-report he had not used PrEP since starting the open-label study and had had no drug detectable in his blood. His HIV had no drug resistance mutations.

Putting together HIV incidence in the randomised and open-label phases, HIV incidence was 0.4% a year in people allocated to PrEP. This compared with 0.91% in people allocated to PrEP in the randomised phase alone and to 6.6% in people allocated to placebo; it implies 94% fewer HIV infections in those given PrEP versus those given placebo.

Participants used an average of 18 pills a month according to pharmacy returns but this is probably an overestimate because, after the results from the randomised study were announced, participants became reluctant to return their PrEP bottles in case PrEP became unavailable after the trial (in fact, fully reimbursable PrEP became available in France from the beginning of this year.)

During the open-label study a third of participants were diagnosed with a new sexually transmitted infection. Of these 38% were diagnosed with gonorrhoea, 42% with chlamydia and 21% with syphilis. Three individuals (1%) were diagnosed with hepatitis C.

There was no significant change between the randomised phase and the open-label phase in the median number of occasions of sex or sexual partners. But there was a significant decrease in condom use for receptive anal intercourse. Condom use as the receptive partner varied between 40 and 25% during the randomised study. During the open-label study, it varied between 20 and 30%.

Safety was good with a low rate of serious adverse events (4%). One participant discontinued PrEP because of a decrease in creatinine clearance, but more as a precaution as high actual relative loss in kidney function was slight: his creatinine clearance was 81 millilitres per minute at the start of the open-label study and 76 at discontinuation.

Drug-related gastrointestinal adverse events were fairly common. Diarrhoea was reported by 10% of participants, nausea by 11%, abdominal pain by 8% and other gastrointestinal symptoms. The only life-threatening adverse event was a stroke, in a participant who already had a cerebral aneurysm (blood vessel dilation). This was not regarded as drug-related.

Further data will be forthcoming from IPERGAY and the French health ministry has made the collection of behavioural and safety data a requirement for joining the rollout programme.

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

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## **Dating Sites May Help Spread HIV: Study**

Angela Laguipo, Tech Times | 2.28

With the vast craze over social media in the past few years, dating sites joined the fad with millions of users. These hook-up sites may actually help spread Human Immunodeficiency Virus (HIV), adding up to new infections, a new study says.

In a study published in the journal Public Health Reports, researchers from Brown University, Rhode Island Department of Health and The Miriam Hospital found that more than 60 percent of men who have sex with men (MSM) from Rhode Island diagnosed with HIV in 2013 said that they met their sexual partners online.

### **They Met Partners Online**

A total 74 new cases of HIV has been diagnosed in Rhode Island in 2013. Three of five were bisexual, MSM and gay. Of the 43 individuals, 22 reported that they believe the virus came from someone they met in an online dating site.

"This is one of the first studies to document how common Internet site use is among people newly diagnosed with HIV and highlights important opportunities to partner with hookup sites to advance public health," said Amy Nunn, director of the Rhode Island Public Health Institute and associate professor at Brown University.

The researchers noted five most popular dating sites namely Scruff, Adam4Adam, Manhunt, Craigslist and Grindr. Some of these sites are also popular among women. Many young men who have sex with men are meeting sexual partners through these sites.

### **What Can Be Done?**

#### **Public Health Partnership**

Public health agencies struggle to sustain informational campaigns on various websites because most of these charge for advertising. It is very expensive for these organizations to post advertisements but these websites should also participate in information dissemination regarding STDs especially that they are promoting risky behaviors among users.

The researchers call for dating sites and apps to use warnings about sexually transmitted diseases (STDs) like HIV. They also recommend that these sites establish partnership with public health agencies in the aim to spread information about the risks of sexual relationships made through these sites.

"We would like to see more of these companies stepping up to the plate to work with public health departments," Dr. Philip Chan from The Miriam Hospital said. They gave credit to websites like Adam4Adam and Manhunt for taking a step toward providing a way for users to list on their profile about their HIV status.

### Information Dissemination

Education is the key to curb the spread of STDs including HIV. The goal of the research is to promote information dissemination through prevention messaging. This tool will help prevent further HIV transmission.

"A study like this is an urgent call to action for greater collaboration around education to address the health needs of men who have sex with men," said Dr. Nicole Alexander-Scott, director of the Rhode Island Department of Health.

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

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## Scientific Papers/Conference Abstracts

### Survey of partner notification practices for sexually transmissible infections in the United States

Desir FA, Ladd JH, Gaydos CA. *Sexual Health* 2016; [Epub ahead of print]

**Background:** Partner notification (PN) for sexually transmissible infections (STIs) is a vital STI control method. The most recent evaluation of PN practices in the United States, conducted in 1999, indicated that few STI patients were offered PN services. The objectives of this study were to obtain a preliminary understanding of the current provision of PN services in HIV/STI testing sites throughout the US and to determine the types of PN services available.

**Methods:** A convenience sample of 300 randomly selected testing sites was contacted to administer a phone survey about PN practices. These sites were from a large database maintained by the Centers for Disease Control and Prevention. Sites were eligible to participate if they provided testing services for chlamydia, gonorrhoea, HIV or syphilis and were not hospitals or Planned Parenthood locations.

**Results:** Of the 300 eligible sites called, 79 sites were successfully reached, of which 74 agreed to participate, yielding a response rate of 24.7% and a cooperation rate of 93.7%. Most surveyed testing sites provided some form of PN service (anonymous or non-anonymous) on site or through an affiliate for chlamydia (100%), gonorrhoea (97%), HIV (91%) and syphilis (96%) infection. Anonymous PN services were available at 67–69% of sites. Only 6–9% of sites offered Internet-based PN services.

**Conclusions:** Most surveyed testing sites currently offer some type of PN service for chlamydia, gonorrhoea, HIV or syphilis infection. However, approximately one-third of surveyed sites do not offer anonymous services. Novel, Internet-based methods may be warranted to increase the availability of anonymous services.

View the paper online: [Abstract](#)

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## Successful Implementation of HIV Preexposure Prophylaxis: Lessons Learned From Three Clinical Settings

Marcus JL, Volk JE, Pinder J, et al. *Current HIV/AIDS Reports* 2016; [Epub ahead of print]

### Abstract:

The past 3 years have marked a transition from research establishing the safety and efficacy of HIV preexposure prophylaxis (PrEP) to questions about how to optimize its implementation. Until recently, PrEP was primarily offered as part of randomized controlled trials or open-label studies. These studies highlighted the key components of PrEP delivery, including regular testing for HIV and other sexually transmitted infections (STIs), adherence and risk-reduction support, and monitoring for renal toxicity. PrEP is now increasingly provided in routine clinical settings. This review summarizes models for PrEP implementation from screening through initiation and follow-up, focusing on the strengths and weaknesses of three delivery systems: a health maintenance organization, an STI clinic, and a primary care practice. These early implementation experiences demonstrate that PrEP can be successfully delivered across a variety of settings and highlight strategies to streamline PrEP delivery in clinical practice.

View the paper online: [Abstract](#)

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## Current and (Potential) Future Effects of the Affordable Care Act on HIV Prevention

Viall AH, McCray E, Mermin J, et al. *Current HIV/AIDS Reports* 2016; [Epub ahead of print]

### Abstract:

Recent advances in science, program, and policy could better position the nation to achieve its vision of the USA as a place where new HIV infections are rare. Among these developments, passage of the Patient Protection and Affordable Care Act (ACA) in 2010 may prove particularly important, as the health system transformations it has launched offer a supportive foundation for realizing the potential of other advances, both within and beyond the clinical arena. This article summarizes opportunities to expand access to high-impact HIV prevention interventions under the ACA, examines whether available evidence indicates that these opportunities are being realized, and considers potential challenges to further gains for HIV prevention in an era of health reform. This article also highlights the new roles that HIV prevention programs and providers may assume in a health system no longer defined by fragmentation among public health, medical care, and community service providers.

View the paper online: [Abstract](#)

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## Occupational HIV Transmission Among Male Adult Film Performers — Multiple States, 2014

Wilken JA, Ried C, Ricket P, et al. *MMWR* 2016;65(5):110-114

In 2014, the California Department of Public Health was notified by a local health department of a diagnosis of acute human immunodeficiency virus (HIV) infection\* and rectal gonorrhoea in a male adult

film industry performer, aged 25 years (patient A). Patient A had a 6-day history of rash, fever, and sore throat suggestive of acute retroviral syndrome at the time of examination. He was informed of his positive HIV and gonorrhea test results 6 days after his examination. Patient A had a negative HIV-1 RNA qualitative nucleic acid amplification test (NAAT)<sup>†</sup> 10 days before symptom onset. This investigation found that during the 22 days between the negative NAAT and being informed of his positive HIV test results, two different production companies directed patient A to have condomless sex with a total of 12 male performers. Patient A also provided contact information for five male non-work-related sexual partners during the month before and after his symptom onset. Patient A had additional partners during this time period for which no locating information was provided. Neither patient A nor any of his interviewed sexual partners reported taking HIV preexposure prophylaxis (PrEP). Contact tracing and phylogenetic analysis of HIV sequences amplified from pretreatment plasma revealed that a non-work-related partner likely infected patient A, and that patient A likely subsequently infected both a coworker during the second film production and a non-work-related partner during the interval between his negative test and receipt of his positive HIV results. Adult film performers and production companies, medical providers, and all persons at risk for HIV should be aware that testing alone is not sufficient to prevent HIV transmission. Condom use provides additional protection from HIV and sexually transmitted infections (STIs). Performers and all persons at risk for HIV infection in their professional and personal lives should discuss the use of PrEP with their medical providers.

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

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## Declines in Unintended Pregnancy in the United States, 2008–2011

Finer LB, Zolna MR. *N Engl J Med* 2016;374:843-852

### Background

The rate of unintended pregnancy in the United States increased slightly between 2001 and 2008 and is higher than that in many other industrialized countries. National trends have not been reported since 2008.

### Methods

We calculated rates of pregnancy for the years 2008 and 2011 according to women's and girls' pregnancy intentions and the outcomes of those pregnancies. We obtained data on pregnancy intentions from the National Survey of Family Growth and a national survey of patients who had abortions, data on births from the National Center for Health Statistics, and data on induced abortions from a national census of abortion providers; the number of miscarriages was estimated using data from the National Survey of Family Growth.

### Results

Less than half (45%) of pregnancies were unintended in 2011, as compared with 51% in 2008. The rate of unintended pregnancy among women and girls 15 to 44 years of age declined by 18%, from 54 per 1000 in 2008 to 45 per 1000 in 2011. Rates of unintended pregnancy among those who were below the federal poverty level or cohabiting were two to three times the national average. Across population subgroups, disparities in the rates of unintended pregnancy persisted but narrowed between 2008 and 2011; the incidence of unintended pregnancy declined by more than 25% among girls who were 15 to 17 years of age, women who were cohabiting, those whose incomes were between 100% and 199% of

the federal poverty level, those who did not have a high school education, and Hispanics. The percentage of unintended pregnancies that ended in abortion remained stable during the period studied (40% in 2008 and 42% in 2011). Among women and girls 15 to 44 years of age, the rate of unintended pregnancies that ended in birth declined from 27 per 1000 in 2008 to 22 per 1000 in 2011.

### Conclusions

After a previous period of minimal change, the rate of unintended pregnancy in the United States declined substantially between 2008 and 2011, but unintended pregnancies remained most common among women and girls who were poor and those who were cohabiting. (Funded by the Susan Thompson Buffett Foundation and the National Institutes of Health.)

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

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## Resources, Webinars, & Announcements

### Get Involved in National Women and Girls HIV/AIDS Awareness Day 2016

Office on Women's Health

[National Women and Girls HIV/AIDS Awareness Day](#) is an annual observance that raises awareness of the impact of HIV and AIDS on women and girls. Every year on March 10, local, state, and national organizations come together to educate and support women and girls in HIV prevention, treatment, and care. **The theme for this year is "The Best Defense Is a Good Offense."** When it comes to sex, the best defenses against HIV are getting tested, using condoms consistently, not abusing drugs or alcohol, and talking to your doctor about pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) if you think you're at risk for HIV.

Regardless of the type of relationship you are in, HIV prevention is key. Put your **#BestDefense** into play!

#### What can you do on March 10?

- Visit the [National Women and Girls HIV/AIDS Awareness Day website](#) for fact sheets, posters, and social media tools.
- Live near Washington, DC? Grab your girlfriends and [walk with us!](#)
- Plan a testing or educational event. Use these [event ideas](#).
- Talk to your girlfriends about the [steps to staying safe and protected from HIV](#).
- Join the National Women and Girls HIV/AIDS Awareness Day [Thunderclap](#).
- Use **#NWGHAAD** and **#BestDefense** to talk about how you are protecting yourself and others from HIV.

Meet the [2016 Ambassadors](#).

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### WEBINAR: STDs, the Genital Microbiome and HIV Transmission: What is Happening Down There?

**DATE:** March 10

**TIME:** 1:00 – 2:00 PM ET

Antiretroviral therapy (ART) dramatically reduces HIV transmission when used as treatment or as PrEP, but the global rate of new HIV infections currently outstrips our ability to provide ART. Most of these new HIV infections are acquired through sex, when the mucosal lining of the vagina, penis or rectum is exposed to HIV-infected genital fluids. Sexual HIV transmission is surprisingly inefficient, with a per-contact risk under 1% for most exposures. Today's presentation will focus on how this risk is dependent on the dynamic interaction between our immune system and microbes – both HIV, other STIs and the larger microbiome – at the mucosal surfaces of the genital tract and gut, and will highlight some challenges of translating these research findings into new HIV prevention strategies.

Dr. Rupert Kaul is dually trained as a clinical Infectious Disease specialist and a PhD immunologist, and is the director of the Infectious Diseases Division at the University of Toronto and University Health Network. His research is focused on the interaction between genital infections and mucosal immunology, and seeks to develop new ways to prevent and ameliorate HIV infection. This research is based in participant cohorts from Canada, Kenya, Uganda and South Africa, with the support of a University of Toronto / OHTN Endowed Chair in HIV Research.

On March 10 at 1:00 pm ET, participants can join the event by clicking [this link](#) and calling 800-619-7490.

For more information: [Click here](#)

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## Job/Internship Postings

### Disease Intervention Specialist (Communicable Disease Investigator) – Orange County

**Organization:** Orange County Health Care Agency, Disease Control and Epidemiology Division  
**Salary:** \$21.03 - \$28.15 Hourly  
**App. Deadline:** Open until filled

#### The Opportunity:

The Disease Intervention Specialist is a trained health professional who practices communicable disease intervention at the individual level with patients, sex partners, and others suspected of having an STD, HIV, or other communicable disease. The CDI provides responsive, high quality services to the local health jurisdiction, representatives of outside agencies, and members of the public by providing accurate, complete, and up-to-date information in a courteous, efficient, and timely manner. The main objective of the activities are to prevent and control disease transmission by ensuring that people who have been diagnosed or exposed to a communicable disease are promptly examined and adequately treated.

#### IDEAL CANDIDATE

The ideal candidate will be bilingual in Spanish. In addition, the ideal candidate will work independently, but on a team collaboratively, and have extensive experience and/or knowledge in:

- **Technical Experience | Technical Knowledge**

- Providing targeted outreach and educating about Public Health issues, disease intervention/prevention/early detection, and appropriate resources
- Understanding and applying Public Health laws and regulations
- Interviewing and counseling of patients diagnosed with communicable diseases
- Gathering/analyzing data to identify sources of infection
- Working with online reporting and data systems (e.g. CalREDIE, LEO)
- Prioritizing and managing a workload that includes a caseload of clients
- Utilizing social media and new technology (e.g. dating websites, GRINDR, Craig's List, Adam4Adam, etc...) to facilitate public health investigations
- **Oral Communication Skills | Written Communication Skills**
  - Communicating effectively to persuade and inform, with sensitivity, tact, and diplomacy, to their clients
  - Preparing detailed case write-ups and meticulous reporting
- **Relationship Building | Interpersonal Skills**
  - Building collaborative partnerships with private and public healthcare facilities
  - Establishing a strong trust and rapport with clients to enhance disease intervention and prevention efforts

For detailed information on how to apply, [click here](#).

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## STI/HIV Social Worker – San Mateo County Public Health, STI Program

**Organization:** San Mateo County Public Health Division, Sexually Transmitted Infection Program  
**Location:** San Mateo, CA  
**Salary:** \$4,985 - \$7,348 /Month  
**App. Deadline:** March 14

### THE POSITION

The San Mateo County Public Health Division's Sexually Transmitted Infection Program seeks a well-qualified STI/HIV Social Worker II/III to provide a variety of services including on-going clinic based case management and short term HIV/STI risk reduction counseling.

The current vacancy is located in San Mateo, CA, but will travel throughout the County to see clients at other sites, attend meetings, case conferences, etc.

Primary responsibilities will include:

Meet with clients at least twice a year to determine eligibility for program; intake process for all new clients; program enrollment; enrollment and registration into county, state and federal programs; psycho-social assessment; provide on-going support as needed; develop linkages for clients to adjunct services (MHA emergency housing and financial services; ACRC food vouchers; HRTC psychotherapy services; Medical-Psychiatry; Dental Services, Psychiatry; benefit services, and other resources as needed); one-to-one support (up to and including, medication adherence, wellness health promotion, appointment follow up, assist with travel to appointments, syringe exchange services, etc.); track clients; periodic check ins with patients who have fallen out of care; write reports or document work time spent with client in electronic medical records, statewide database, and other data keeping systems; meet with collaborators, and any other meetings with persons related to the program or on behalf of the

client; attend monthly or bi-monthly provider case conferences; participate in specialized case conferences for patients; participate in all bi-monthly held mental health meetings; participate in monthly program team meetings; participate in monthly providers meeting; and participate in quarterly all staff meetings.

The ideal candidate will have experience with:

- Providing case management services to HIV clients;
- Professional, personal and/or volunteer experience in HIV care and prevention programs with varied populations;
- Risk/harm reduction counseling;
- Working as part of an integrated treatment team; and
- Knowledge of AIDS Drug Assistance Program (ADAP) and Office of AIDS Health Insurance Premium Payment (OA-HIPP).
- Fluency in both English and Spanish is strongly preferred

For more information: [Click here](#)

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## STD/HIV Service Integration Unit Chief – CDPH STDCB

**Organization:** California Department of Public Health, STD Control Branch

**Location:** Richmond, CA

### **Job Summary**

Under the supervision of the Health Promotion and Healthcare Quality Improvement (HPHQI) Section Chief, the STD/HIV Service Integration Unit Chief establishes and maintains effective consultative and collaborative relationships with state, local, and non-governmental partners to enhance and integrate STD/HIV prevention and control activities. Within this role, the STD/HIV Service Integration Unit Chief leads a team of public health professionals in planning, implementing, evaluating, and improving projects and interventions related to HIV partner services, HIV prevention among STD patients, and quality STD clinical care among HIV-infected persons. This position oversees local health jurisdiction (LHJ) STD/HIV Service Integration funding including managing standardized processes for selection of awardees, approving budgets and activities within LHJ Scopes of Work, and providing ongoing monitoring of LHJ performance.

### **Required Qualifications**

- BA/BS degree with a major in a related field and four years of experience in administrative analysis or operations research; or an equivalent combination of education and experience
- Experience in public health program management
- Experience developing and maintaining collaborations with diverse partner groups
- Experience supervising staff
- Experience writing and/or managing grants, drafting formal progress reports, or similar
- Experience participating in a strategic planning and/or prioritization processes
- Experience with program evaluation, including planning, implementation, and monitoring, and the summarizing of results
- Proficiency with Microsoft applications: Word, Excel, PowerPoint, Outlook
- Basic content knowledge in STD epidemiology and prevention and control strategies, including knowledge of STD screening recommendations and other STD-related clinical interventions

- Knowledge of IRB and HIPAA guidelines associated with conducting public health evaluations and research
- Excellent and effective time management skills and ability to juggle multiple priorities and meet competing deadlines
- Leadership skills and independent initiative and drive
- Ability to know when to seek counsel on issues outside one's abilities or knowledge
- Excellent interpersonal and communication skills, including professionalism, diplomacy, and discretion in verbal and written communications, and ability to communicate professionally with multiple levels of staff

**Preferred Qualifications**

- Master's degree in Public Health or related field and two or more years of public health work experience
- Experience working in the field of HIV Prevention, Care, or Surveillance
- Experience crafting and negotiating contracts and budgets
- Knowledge of basic medical terminology

**\*\* Directions for applying to this position \*\***

Candidates interested in applying for this position, please visit the UCSF website at:

<http://ucsfhr.ucsf.edu/careers/>. Click on 'Search openings' and enter in **44332** under 'Req number' to view the posting. Please submit your cover letter and resume electronically to the UCSF Careers website.

**Aaron Kavanaugh**

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 STD Control Branch, California Department of Public Health  
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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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