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National Stories

New scientific evidence of sexual transmission of the Zika virus

As reported by Science Daily | 4.15.2016

A study by researchers from Inserm, the Paris Public Hospitals (Bichat Hospital, AP-HP), Aix-Marseille University, and the National Reference Centre for Arboviruses confirms that the ZIKA virus can be transmitted sexually. Their analyses have shown 100% genetic correlation between the form of the virus present in a man who contracted the virus in Brazil and that of a woman who had never travelled in the epidemic area, but who had sexual relations with him. These results are published in The New England Journal of medicine.

The ZIKA virus, a member of the Flavivirus family, is almost exclusively transmitted to humans by Aedes mosquitoes. Although Zika infection usually causes mild symptoms, it can be responsible for severe neurological complications, particularly in the infant of a woman infected while pregnant. Some indications of possible sexual transmission of the virus have been reported before now.

For the first time, and to take things further, French researchers have been able to culture the infecting virus from two people seeking a consultation for suspected ZIKA infection. Specimens of urine, saliva and blood were taken from a man who returned from Brazil, and had contracted the virus there. The same specimens were taken from a sick woman who had sexual relations with this man, but who had never travelled to an epidemic area.

While the virus was detected in the urine and saliva of the woman, analysis of the specimens showed that it was absent from the blood and saliva of the man, making it unlikely that transmission occurred by these routes. The researchers then tested his semen for the virus, and detected high viral loads at 15 days and at 3 weeks after the patient's return from Brazil (approximately 300 million copies/ml).

The virus from both persons was individually sequenced (using a saliva sample from the woman and a semen sample from the man) for genetic analysis. Examination showed 100% correlation between the two genetic sequences. Apart from 4 mutations, all of them "synonymous," the nucleotide sequences both encoded an identical form of the virus.

"Our work confirms, using molecular analyses, that sexual transmission of the ZIKA virus exists, and should be taken into consideration when making recommendations, due to its persistence in the semen several weeks after infection. The period for which men should systematically have protected sexual relations (even oral) needs to be defined," explains Yazdan Yazdanpanah.

Journal Reference:

Eric D'Ortenzio, Sophie Matheron, Xavier de Lamballerie, Bruno Hubert, Géraldine Piorkowski, Marianne Maquart, Diane Descamps, Florence Damond, Yazdan Yazdanpanah, Isabelle Leparc-Goffart. **Evidence of Sexual Transmission of Zika Virus.** *New England Journal of Medicine*, 2016; DOI: [10.1056/NEJMc1604449](https://doi.org/10.1056/NEJMc1604449)

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

Health Officials Split Over Advice on Pregnancy in Zika Areas

Donald G. McNeil Jr., The New York Times | 4.14

As the Zika virus bears down on the United States, federal health officials are divided over a politically and ethically charged question: Should they advise American women to delay pregnancy in areas where the virus is circulating?

Some infectious disease experts are arguing that avoiding conception is the only sure way to prevent the births of deformed babies, according to outside researchers who serve on various advisory panels.

Women's health specialists, on the other hand, counter that the government should not tell women what to do with their bodies. Indeed, federal health officials have never advised all the women in a

region of the country to stop having children. Moreover, they say, most babies conceived during Zika epidemics in Latin America have been born healthy.

Several federal experts central to the discussion declined to be interviewed for this article. Dr. Thomas R. Frieden, the director of the Centers for Disease Control and Prevention, described the internal debate as “a very long conversation.”

For now, “we do not have a recommendation to not become pregnant,” Dr. Frieden said at a “Zika summit” held recently at disease agency headquarters in Atlanta. “We do recommend access to contraception.”

On Wednesday, the agency confirmed what many experts already believed: that the mosquito-borne virus, which is usually mild in adults, can cause severe brain damage in infants.

In view of the gathering evidence, health officials in some countries struck by Zika epidemics, including El Salvador and Colombia, have urged women to avoid pregnancy.

Dr. Marcos Espinal, who directs the Zika response of the Pan American Health Organization, an arm of the World Health Organization, said in an interview that he thought advising women to avoid conception during an epidemic’s relatively brief peak months, as Colombia did, “is sound advice.”

Yet the W.H.O. does not follow that policy. Dr. Bruce Aylward, the agency’s head of emergency response, called avoiding pregnancy “a complicated decision that is different for each individual woman.”

Currently, the question affects Americans only in Puerto Rico, the United States Virgin Islands and American Samoa, where the Zika virus is circulating locally. But if the virus spreads as expected this summer, women in Hawaii and many Gulf Coast states may also be faced with tough choices.

Despite the C.D.C.’s stance, Puerto Rico’s health secretary, Dr. Ana Ríos, has been advising women to avoid pregnancy, although she has done so in public interviews, not in a large health campaign. Women on the island may be following her advice, she said; preliminary figures indicate that there are 8 percent fewer pregnancies than there were at this time last year.

For women living on those islands, the disease agency’s current guidelines do not advocate delaying pregnancy, instead calling the timing of conception a “deeply personal and very complex decision” and suggesting that women consult their doctors for “pregnancy planning.”

But tourists visiting the islands receive specific advice to avoid pregnancy for eight weeks after a visit, and for six months if male partners have had symptoms of Zika infection.

One expert familiar with the debate, Michael T. Osterholm, director of the University of Minnesota’s Center for Infectious Disease Research and Policy, described it as “two groups describing an elephant, one looking at the head and the other at the tail.”

Dr. William Schaffner, the chairman of department of preventive medicine at Vanderbilt University Medical School, who also described the outlines of the split, said that withholding conception advice might leave couples adrift.

“They have to think it through by themselves,” he said. “They may hear it from their doctors or mothers or friends at the beauty parlor, but not from the C.D.C.”

Advocates of delaying pregnancy give several reasons.

First, they do not believe that even the most aggressive mosquito-control efforts can protect pregnant woman 24 hours a day for nine months.

No country yet has stopped dengue or chikungunya, which, like Zika, are spread by the *Aedes aegypti* mosquito, and the disease agency itself has warned that reductions of 80 percent to 90 percent in those mosquito populations sometimes does not reduce disease transmission.

Second, no vaccine is expected to be ready for at least two years.

Third, evidence is mounting that Zika outbreaks are intense but brief. In French Polynesia in 2013, the virus infected 66 percent of the population within seven months and then disappeared.

Because women who recover from Zika appear to be permanently immune, experts argue that delaying conception spares them the risk of having a child with severe birth defects, along with the agonizing worry — and lets them conceive safely a year later.

“It’s a no-brainer,” said Dr. Peter J. Hotez, the dean of the National School of Tropical Medicine at Baylor College of Medicine. “They should say, ‘Don’t get pregnant — watch TV for six months and you won’t have a badly hurt baby.’”

In framing the language of the guidelines, Dr. Frieden said he was “guided by the perspective” of Dr. Denise J. Jamieson, a medical officer in the disease agency’s division of reproductive health.

In an interview, Dr. Jamieson described birth defects as a rare complication of Zika infection. Even during an epidemic, she said, “most women will have healthy babies.”

Further, Dr. Jamieson said, delays “would also prevent wanted pregnancies,” especially in older women struggling with fertility, for example.

Advice from government doctors on such personal decisions, she added, “is not likely to be effective.”

Asked what advice she would have given during the last American rubella epidemic — which killed or severely handicapped an estimated 20,000 babies — she answered: “I would have said, ‘This is an extraordinarily risky time to get pregnant.’”

But she does not endorse giving the same advice this time, she said, because rubella was unavoidable in those prevaccine days, whereas now, “highly motivated women can take measures to avoid mosquito bites.”

Local health officials have offered a variety of perspectives.

In the United States Virgin Islands, Michelle S. Davis, the territory's new health secretary, said she had not advocated pregnancy delay, although individual doctors may be doing so.

The story has played out differently in Puerto Rico, where the C.D.C. has said there could be thousands of pregnant women infected by late summer.

Dr. Ríos, the health secretary, suggested in several public interviews that women delay conception until more is known about the virus. She also instructed public clinics to distribute condoms.

She was accused of alarmism, and the island's Roman Catholic archbishop criticized her condom plan.

But in an interview at the Atlanta summit meeting, she said that a new pregnancy surveillance network created by the disease agency for the epidemic suggested that women there may be heeding her advice. Births are expected to number 28,000 this year, below last year's total of 30,323.

Prominent gynecologists in Puerto Rico also are advising patients to avoid pregnancy.

Dr. Jose Alvarez Romagosa, a fertility specialist at the Auxilio Mutuo Hospital in San Juan and star of a popular television show, "Latin Doctors," said he had dissuaded three patients from conceiving in a single day.

Dr. Manuel Navas, a fertility specialist and medical director of HIMA-San Pablo Hospital in Fajardo, a town where some of the island's earliest Zika infections were detected, said he, too, was discouraging most patients from conceiving unless they were desperate for a child and he was sure they understood the risks.

That was the advice he would give his daughter, he added.

Asked how his patients reacted, he said, "They appreciate it."

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

Studies Begin to Test Long-Acting Antibody Infusions for HIV Prevention

As reported by POZ | 4.12

Two large-scale, multiyear studies of infusions of antibodies as pre-exposure prophylaxis (PrEP) against HIV are beginning this spring. The two Phase III, double-blind, placebo-controlled AMP Studies will give intravenous infusions of the [broadly neutralizing antibody VRC01](#) every eight weeks to see whether it is safe, tolerable and effective at preventing HIV among high-risk individuals. The studies are projected to enroll 4,200 adults.

Research has shown that VRC01 blocks up to 90 percent of the world's HIV strains.

The studies may also provide information about what level of broadly neutralizing antibodies a vaccine or other long-acting form of PrEP is needed to protect against HIV over the long term.

One study, called HVTN 703/HPTN 085, has just begun and will operate out of 24 sites in Brazil, Peru and the United States, enrolling 2,700 transgender individuals and men who have sex with men (MSM). The other study, HVTN 703/HPTN 081, will begin later in the spring and will enroll 1,500 sexually active women at 15 sites in sub-Saharan Africa.

In each of the trials, the participants will be randomized to receive a total of 10 intravenous infusions—one given every eight weeks—of VRC01 at a dose of 30 milligrams per kilogram, a dose of 10 mg/kg or a saline solution placebo. After the 10th infusion, the participants will be followed for 20 more weeks.

Results of the trials are expected in 2022.

The participants will undergo testing for HIV every four weeks and at any point that they report possibly having been exposed to the virus. Those who test positive for HIV will remain in the study for follow-up and be referred to medical care for the virus.

All participants will receive HIV prevention counseling, as well as condoms and lubricant. They will receive counseling about and referral for post-exposure prophylaxis (PEP) following a potential exposure to the virus and will also be referred to available local programs through which they can obtain daily oral Truvada (tenofovir/emtricitabine) as pre-exposure prophylaxis (PrEP).

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

For a Q&A about the studies, [click here](#).

For information recruitment for the study of MSM and trans individuals, [click here](#).

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

New research explains why HIV is not cleared by the immune system

Discovery provides new therapeutic strategies for HIV antivirals, vaccines and cancer

As reported by Science Daily

Scientists at the University of North Carolina (UNC) School of Medicine and Sanford Burnham Prebys Medical Discovery Institute (SBP) have identified a human (host) protein that weakens the immune response to HIV and other viruses. The findings, published today in *Cell Host & Microbe*, have important implications for improving HIV antiviral therapies, creating effective viral vaccines, and advance a new approach to treat cancer.

"Our study provides critical insight on a paramount issue in HIV research: Why is the body unable to mount an efficient immune response to HIV to prevent transmission?" said Sumit Chanda, Ph.D., professor and director of SBP's Immunity and Pathogenesis Program and co-senior author of the study. "This research shows that the host protein NLRX1 is responsible--it's required for HIV infection and works by repressing the innate immune response."

The innate immune response works by producing a cascade of signaling chemicals (interferons and cytokines) that trigger cytotoxic T cells to kill pathogens. Increasing evidence suggests that mounting an early, potent innate immune response is essential for the control of HIV infection, and may improve the effectiveness of vaccines.

"Importantly, we were able to show that deficiencies in NLRX1 reduce HIV replication, suggesting that the development of small molecules to modulate the innate immune response may inhibit viral transmission and promote immunity to infection," said Chanda. "We anticipate expanding our research to identify NLRX1 inhibitors."

How NLRX1 reduces innate immunity to HIV

Although HIV is a single-stranded RNA virus, after it infects an immune cell it's rapidly reverse transcribed into DNA, increasing the level of DNA found in the fluid portion of a cell (cytosol). Elevated cytosolic DNA triggers a sensor called STING (stimulator of interferon genes) that turns on the innate immune response.

"Until now, the mechanism by which NLRX1 promoted HIV infection was unexplored. We have shown that NLRX1 interacts directly with STING, essentially blocking its ability to interact with an enzyme called TANK-binding kinase 1 (TBK1)," said Haitao Guo, Ph.D., senior postdoctoral research associate in the laboratory of Jenny Ting, Ph.D., a University of North Carolina Lineberger Comprehensive Cancer Center member, the William R. Kenan Jr. Professor of Microbiology and Immunology at the UNC School of Medicine and lead author of the study. "The STING-TBK1 interaction is a critical step for interferon production in response to elevated cytosolic DNA, and initiates the innate immune response."

"This research expands our understanding of the role of host proteins in viral replication and the innate immune response to HIV infection, and can be extended to DNA viruses such as HSV and vaccinia," added Guo.

Relevance to cancer

"Our discovery that NLRX1 reduces the immune response to HIV is similar to the discovery of host immune checkpoints, such as PD-L1 and CTLA-1, that control the immune response to cancer," said Ting, co-senior author of the study.

Immune checkpoints are immunological "brakes" that prevent the over-activation of the immune system on healthy cells. Tumor cells often take advantage of these checkpoints to escape detection of the immune system. Several FDA-approved drugs that target checkpoints, called checkpoint inhibitors, are now available to treat certain cancers.

"Checkpoint inhibitors have made a huge impact on cancer treatment, and significant investment by the biotech/pharmaceutical sector is being made to identify STING inhibitors as the next generation of immune-oncology therapeutics," said Ting. "This study, showing that NLRX1 is a checkpoint of STING, sheds more light on the topic and will help advance those efforts."

Journal Reference:

Haitao Guo, Renate König, Meng Deng, Maximilian Riess, Jinyao Mo, Lu Zhang, Alex Petrucelli, Sunnie M. Yoh, Brice Barefoot, Melissa Samo, Gregory D. Sempowski, Aiping Zhang, Anamaris M. Colberg-Poley,

Hui Feng, Stanley M. Lemon, Yong Liu, Yanping Zhang, Haitao Wen, Zhigang Zhang, Blossom Damania, Li-Chung Tsao, Qi Wang, Lishan Su, Joseph A. Duncan, Sumit K. Chanda, Jenny P.-Y. Ting. **NLRX1 Sequesters STING to Negatively Regulate the Interferon Response, Thereby Facilitating the Replication of HIV-1 and DNA Viruses.** *Cell Host & Microbe*, 2016; 19 (4): 515 DOI: [10.1016/j.chom.2016.03.001](https://doi.org/10.1016/j.chom.2016.03.001)

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

First diagnosed case of Alzheimer's disease in HIV-positive individual reported

Press Release, Georgetown University Medical Center, as reported by EurekAlert! | 4.15

Georgetown University researchers are reporting the first case of Alzheimer's disease diagnosed in an HIV-positive individual. The finding in a 71-year-old man triggers a realization about HIV survivors now reaching the age when Alzheimer's risk begins to escalate.

[Published online](#) in the open access journal *Alzheimer's & Dementia: Diagnosis, Assessment & Disease Monitoring*, neurologist [R. Scott Turner, MD, PhD](#), diagnosed the patient after a PET scan showed deposition of amyloid in the brain. Until this point, Turner says, clinicians thought that individuals with HIV may not develop AD because HIV-related inflammation in the brain may prevent amyloid clumps from forming.

"This patient may be a sentinel case that disputes what we thought we knew about dementia in HIV-positive individuals," says Turner, who leads the Memory Disorders Program at Georgetown University Medical Center.

In addition, Turner says the finding suggests that some older HIV-positive patients with dementia may be misdiagnosed with HIV-associated neurocognitive disorders (HAND) when they may be developing AD. It also may be possible that some patients experience HAND and AD -- a new type of mixed dementia, Turner says. "Chronic HIV infection and amyloid deposition with aging may represent a "double-hit" to the brain that results in progressive dementia."

"While it may be challenging to diagnose the cause of dementia in an HIV-positive patient, the diagnosis matters because HAND and AD are treated differently," he says. "For Alzheimer's disease, we now have four FDA-approved drugs and more effective treatments are on the way. For HAND, we prescribe anti-retroviral drugs that have a better chance of penetrating the brain. So getting a correct diagnosis is important, and a critical first step in advancing the field."

HAND will develop in 30-50 percent of individuals with long-term HIV infections. But HAND symptoms are identical to those with AD, Turner says. He adds, "The medical community assumes that dementia with HIV is caused by HAND. Physicians haven't considered Alzheimer's, so it's possible that a number of older HIV-positive individuals may be misdiagnosed."

Published studies to date point to only five individuals with HAND who have undergone amyloid PET imaging, and all were negative; however, the oldest of these patients was 67, Turner says.

Diagnosis of dementia in older HIV-infected individuals is on the rise. HIV-infected adults over 55 comprise the fastest growing age group in the HIV-positive population.

According to the most recent CDC HIV Surveillance Report with data through 2013, 53,000 people in the U.S. living with HIV are 65 and older, the age when Alzheimer's disease risk begins to escalate. That number is expected to double in less than 10 years and doesn't include those who have not been diagnosed. Worldwide, more than 37 million people are living with HIV.

"This case report reveals important new insights into the specific issue of HIV-related neurological impairment," says Jeffrey Crowley, MPH, program director of the National HIV/AIDS Initiative at the O'Neill Institute for National and Global Health Law at Georgetown Law. Crowley is former director of the White House Office of National AIDS Policy and senior advisor on disability policy. "This finding must lead to additional population-based studies, as well as timely clinical and programmatic interventions to better support individuals with HIV who are facing neurological decline."

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

On-the-go diagnosis of HIV and HCV co-infections

Researchers have created the first paper-based electrochemical 'immunosensing' platform for rapid, inexpensive diagnosis of HIV and hepatitis C virus co-infections

As reported by Science Daily | 4.13

HIV and hepatitis C virus (HCV) infections are among the leading causes of death worldwide, and an estimated one-third of people with HIV/AIDS are co-infected with HCV. This makes them more likely to suffer worse outcomes and poses severe public health challenges within Kenya and other African countries as well.

While rapid point-of-care tests for diagnosing sexually transmitted infections are commercially available today and used within developing regions, they tend not to be affordable or accurately quantify the concentrations of the disease markers within a sample, which help to determine the stage of the infection.

But this may soon change. A group of researchers at McGill University in Montreal has recently developed a portable, paper-based electrochemical platform with multiplexing and telemedicine capabilities that may enable low-cost, point-of-care diagnosis of HIV and HCV co-infections within serum samples.

The researchers discuss the design and testing of their device this week in *Biomicrofluidics*, from AIP Publishing. When assessing the device's sensitivity with spiked mouse serum samples, the researchers were able to detect HIV and HCV antibodies at 300 picograms per mL and 750 picograms per mL, respectively -- values lower than currently existing HIV and HCV antibody tests.

The group's work to develop HIV and HCV antibody tests was initiated by a Star in Global Health Award granted by Grand Challenge Canada.

How Does the Diagnosis Work?

"Our experimental setup consists of a paper device with eight electrochemical biosensors -- for handy, one-time, disposable use -- and a custom-made, handheld electrochemical reader, or potentiostat, to

keep costs as low as possible," explained Xinyu Liu, an assistant professor in the Department of Mechanical Engineering at McGill University. "It enables eight [simultaneous tests], four for HIV antibodies, and four for HCV antibodies," Liu said, adding that makes the test broader than existing HIV and HCV point-of-care tests.

To run a test, the paper device is simply inserted into a slot on the potentiostat, and microliter drops of serum sample and reagents are added to each biosensor. Pressing a button triggers the electrochemical measurements.

The device is also compatible with existing internet-based and mobile network-based e-health systems. Data from the eight tests can be directly displayed on an LCD screen of the potentiostat or transmitted to a smartphone or personal computer, and then to a remote site -- a centralized laboratory or hospital - - via the mobile network or Internet for remote diagnoses.

When the researchers explored a potential cross-reaction between the HIV and HCV antibody tests, they found "no significant interference of the two tests," Liu noted. "These results demonstrate that our diagnostic platform shows great potential for diagnosing HIV/HCV co-infections in real patient samples."

The main advantage offered by the platform is its ability to run eight test for HIV and HCV in parallel within 20 minutes with high accuracy, sensitivity and specificity. Beyond this, the platform's "handheld multiplexing potentiostat makes the entire electrochemical platform portable and significantly improves its adaptability to point-of-care applications," Liu explained.

And, given the wide applicability of electrochemical detection to many types of biomolecules, the platform "can be readily extended to the detection of other disease markers such as proteins, metabolites, ions, and nucleic acids," Liu added.

The next step for the researchers is to continue fine-tuning the device for practical use. "We'll explore the stability of the paper device during long-term storage, and then begin real patient sample testing in Canada and Kenya," said Liu. "Our long-term goal is to further extend the functionality of this diagnostic platform by targeting other molecular disease markers."

Journal Reference:

Chen Zhao, Xinyu Liu. **A portable paper-based microfluidic platform for multiplexed electrochemical detection of human immunodeficiency virus and hepatitis C virus antibodies in serum.**

Biomicrofluidics, 2016; 10 (2): 024119 DOI: [10.1063/1.4945311](https://doi.org/10.1063/1.4945311)

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

Scientific Papers/Conference Abstracts

Persons Living with HIV in the United States: Fewer Than We Thought.

Xia Q, Braunstein SL, Wiewel EW, et al. *JAIDS* 2016; [Epub ahead of print]

Objectives:

To estimate the number of persons living with HIV (PLWH) in the United States and describe their care status.

Methods:

Estimates of diagnosed PLWH in New York City (NYC) and other 19 jurisdictions based on HIV case reporting were compared with those based on HIV laboratory reporting. A revised HIV care continuum was constructed based on previously published data.

Results:

The estimate of PLWH based on HIV case reporting was 25.6% higher than that based on HIV laboratory reporting data in NYC. There were 819,200 PLWH in the United States at the end of 2011 (plausible range: 809,800, 828,800), of whom 86% were diagnosed, 72% retained in care (≥ 1 care visit in 2011), 68% on antiretroviral therapy, and 55% virally suppressed (≤ 200 copies/mL).

Conclusions:

The current method based on HIV case reporting may have overestimated PLWH in the United States. While we continue cleaning HIV case reporting data to improve its quality, we should take the opportunity to use comprehensive HIV laboratory reporting data to estimate PLWH at both the national and local level.

View the paper online: [Abstract](#)

Structural Determinants of Antiretroviral Therapy Use, HIV Care Attendance, and Viral Suppression among Adolescents and Young Adults Living with HIV

Kahana SY, Jenkins RA, Bruce D, et al. *PLoS ONE* 2016; 11(4): e0151106.
doi:10.1371/journal.pone.0151106

Background

The authors examined associations between structural characteristics and HIV disease management among a geographically diverse sample of behaviorally and perinatally HIV-infected adolescents and young adults in the United States.

Methods

The sample included 1891 adolescents and young adults living with HIV (27.8% perinatally infected; 72.2% behaviorally infected) who were linked to care through 20 Adolescent Medicine Trials Network for HIV/AIDS Interventions Units. All completed audio computer-assisted self-interview surveys. Chart abstraction or blood draw provided viral load data. Geographic-level variables were extracted from the United States Census Bureau (e.g., socioeconomic disadvantage, percent of Black and Latino households, percent rural) and Esri Crime (e.g., global crime index) databases as Zip Code Tabulation Areas. AIDSvu data (e.g., prevalence of HIV among youth) were extracted at the county-level. Using HLM v.7, the authors conducted means-as-outcomes random effects multi-level models to examine the association between structural-level and individual-level factors and (1) being on antiretroviral therapy (ART) currently; (2) being on ART for at least 6 months; (3) missed HIV care appointments (not having missed any vs. having missed one or more appointments) over the past 12 months; and (4) viral suppression (defined by the corresponding assay cutoff for the lower limit of viral load at each participating site which denoted nondetectability vs. detectability).

Results

Frequencies for the 4 primary outcomes were as follows: current ART use (n = 1120, 59.23%); ART use for ≥ 6 months (n = 861, 45.53%); at least one missed HIV care appointment (n = 936, 49.50); and viral suppression (n = 577, 30.51%). After adjusting for individual-level factors, youth living in more disadvantaged areas (defined by a composite score derived from 2010 Census indicators including percent poverty, percent receiving public assistance, percent of female, single-headed households, percent unemployment, and percent of people with less than a high school degree) were less likely to report current ART use (OR: 0.85, 95% CI: 0.72–1.00, p = .05). Among current ART users, living in more disadvantaged areas was associated with greater likelihood of having used ART for ≥ 6 months. Participants living in counties with greater HIV prevalence among 13–24 year olds were more likely to report current ART use (OR: 1.32, 95% CI: 1.05–1.65, p = .02), ≥ 6 months ART use (OR: 1.32, 95% CI: 1.05–1.65, p = .02), and to be virally suppressed (OR: 1.50, 95% CI: 1.20–1.87, p = .001); however, youth in these areas were also more likely to report missed medical appointments (OR: 1.32, 95% CI: 1.07–1.63, p = .008).

Conclusions

The findings underscore the multi-level and structural factors associated with ART use, missed HIV care appointments, and viral suppression for adolescents and young adults in the United States. Consideration of these factors is strongly recommended in future intervention, clinical practice, and policy research that seek to understand the contextual influences on individuals' health behaviors.

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

Male-to-Male Sexual Transmission of Zika Virus — Texas, January 2016

Deckard DT, Chung WM, Brooks JT, et al. *MMWR* 2016;65(14):372-374

Zika virus infection has been linked to increased risk for Guillain-Barré syndrome and adverse fetal outcomes, including congenital microcephaly. In January 2016, after notification from a local health care provider, an investigation by Dallas County Health and Human Services (DCHHS) identified a case of sexual transmission of Zika virus between a man with recent travel to an area of active Zika virus transmission (patient A) and his nontraveling male partner (patient B). At this time, there had been one prior case report of sexual transmission of Zika virus (1). The present case report indicates Zika virus can be transmitted through anal sex, as well as vaginal sex. Identification and investigation of cases of sexual transmission of Zika virus in nonendemic areas present valuable opportunities to inform recommendations to prevent sexual transmission of Zika virus.

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

Patterns in Zika Virus Testing and Infection, by Report of Symptoms and Pregnancy Status — United States, January 3–March 5, 2016

Dasgupta S, Reagan-Steiner S, Goodenough D, et al. *MMWR* 2016;64: Early Release

CDC recommends Zika virus testing for potentially exposed persons with signs or symptoms consistent with Zika virus disease, and recommends that health care providers offer testing to asymptomatic pregnant women within 12 weeks of exposure. During January 3–March 5, 2016, Zika virus testing was performed for 4,534 persons who traveled to or moved from areas with active Zika virus transmission;

3,335 (73.6%) were pregnant women. Among persons who received testing, 1,541 (34.0%) reported at least one Zika virus-associated sign or symptom (e.g., fever, rash, arthralgia, or conjunctivitis), 436 (9.6%) reported at least one other clinical sign or symptom only, and 2,557 (56.4%) reported no signs or symptoms. Among 1,541 persons with one or more Zika virus-associated symptoms who received testing, 182 (11.8%) had confirmed Zika virus infection. Among the 2,557 asymptomatic persons who received testing, 2,425 (94.8%) were pregnant women, seven (0.3%) of whom had confirmed Zika virus infection. Although risk for Zika virus infection might vary based on exposure-related factors (e.g., location and duration of travel), in the current setting in U.S. states, where there is no local transmission, most asymptomatic pregnant women who receive testing do not have Zika virus infection.

Continue reading the paper online: [Full paper](#)

Resources, Webinars, & Announcements

National Transgender HIV Testing Day

CDC Act Against AIDS Campaign

Dear Colleagues,

On April 18, the Centers for Disease Control and Prevention (CDC) will join our partners to observe the inaugural [National Transgender HIV Testing Day](#), sponsored by the [Center of Excellence for Transgender Health](#), University of California, San Francisco. The Center for Excellence is one of CDC's [Capacity Building Assistance Provider Network](#) partners. This new day of action focuses on HIV testing, prevention, and treatment among transgender people and will encourage local testing events and campaigns for the transgender community.

Transgender people, particularly transgender women, are disproportionately affected by HIV. A 2013 systematic review found that the estimated HIV prevalence (percentage of a population living with HIV) among transgender women was 22% in the United States. Another analysis estimated that HIV prevalence among African American transgender women was as high as 56%. Because transgender people, especially transgender women, are at high risk for acquiring HIV, there is an urgent need to expand HIV testing—the critical first step along the continuum of care—and prevention and treatment initiatives to reach the transgender community.

Transgender people often experience barriers to accessing HIV services because of misperceptions and stigma, lack of knowledge about transgender issues, and social issues such as being underinsured or not having adequate housing or transportation. Eliminating these barriers will help reduce HIV infections among transgender people and provide better care to those living with HIV.

CDC and other organizations are accelerating the implementation of high-impact HIV prevention strategies for the transgender community. These initiatives support the [National HIV/AIDS Strategy's](#) goals of reducing health-related disparities and strengthening the nation's capacity to deliver HIV care for transgender people. The Center of Excellence for Transgender Health recently released the [Transgender HIV Testing Toolkit](#), which will support local efforts to increase knowledge of HIV status and

help educate health care providers on the testing needs of the transgender community. We encourage you to use it and share it.

Some of CDC's HIV testing and prevention activities that focus on the transgender community include:

- **Capacity building assistance** to implement strategies for HIV prevention and strengthen the infrastructure of health departments, community-based organizations, and clinics that serve transgender people.
- **Funding for community-based organizations** that provide services to young transgender people of color and for **health departments** to implement pre-exposure prophylaxis (PrEP) services and data-to-care activities prioritizing transgender people at high risk of HIV infection.
- **[Act Against AIDS](#) communication materials** to reach transgender people.
 - **[Doing It](#)**, which encourages all adults to get tested for HIV and know their status, includes [images](#) and testimonial videos featuring transgender leaders.
 - **[Let's Stop HIV Together](#)**, which raises awareness about HIV and fights stigma, includes the [stories](#) of transgender women.
 - **[HIV Treatment Works](#)**, which encourages people living with HIV to stay in care, features a transgender woman's [story](#) of staying healthy while living with HIV.

Thank you for the vital work you are doing to increase awareness of HIV status and prevent HIV in the transgender community. We have much work left to do, but by using proven prevention tools and working with the transgender community, we can reduce HIV infections and disparities among transgender people.

Sincerely,

/Jonathan H. Mermin/

Jonathan H. Mermin, MD, MPH

RADM and Assistant Surgeon General, USPHS

Director

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Centers for Disease Control and Prevention

www.cdc.gov/nchhstp

/Eugene McCray/

Eugene McCray, MD

Director

Division of HIV/AIDS Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

www.cdc.gov/hiv

Trends in the States: First Quarter 2016

Guttmacher Institute

State legislatures came into session in January and quickly focused on a range of sexual and reproductive health and rights issues. By the end of the first quarter, legislators in 45 states had introduced 1022 provisions. Of the 411 abortion restrictions that have been introduced so far this year, 17 have passed at least one chamber and 21 have been enacted in five states (FL, IN, KY, SD and UT).

This year's legislative sessions are playing out on a crowded stage. The U.S. Supreme Court is considering a case involving a package of abortion restrictions in Texas; that decision, when handed down in June, could reshape the legal landscape for abortion at the state level. Moreover, just as the state legislatures were hitting their stride in late March, the U.S. Food and Drug Administration revised the labeling for mifepristone, one of the two drugs used for medication abortion. That decision immediately put the issue back on the front burner by effectively counteracting policies restricting access to medication abortion in a handful of states. (Notably, the Arizona legislature moved within days to enact a measure limiting the impact of the FDA decision in the state.)

To read the full report: [Click here](#)

Motivational Interviewing Workshops

CHFC

DATE: Monday, April 25, 2016
TIME: 1:00 PM – 4:00 PM (PST)
LOC: Los Angeles

DATE: Wednesday, May 11, 2016
TIME: 1:00 PM – 4:00 PM (PST)
LOC: Oakland

Presenters:

Amber Eisenmann, MS, Director, Learning Exchange, California Family Health Council
Andria Hancock-Crear, MPH, Project Director, Training, California Family Health Council
Erica Neuman, MS, Project Director, Learning Management, California Family Health Council

Overview:

When used consistently and effectively motivational interviewing (MI) is a simple yet innovative counseling technique that can increase birth control continuation rates, reduce unintended pregnancy and high-risk sexual behaviors. Successful implementation of MI techniques have also been shown to increase STD/HIV prevention behaviors and treatment follow through and over all patient satisfaction.

In this workshop, participants will receive MI training and get hands-on practice using MI techniques to provide patient-centered sexual and reproductive health counseling. Participants will also learn how utilizing MI techniques can save time and improve patient health outcomes and staff morale in diverse settings.

What Will You Learn?

After attending this training, participants will be able to:

- Describe the Stages of Change Model and the basic principles of motivational interviewing
- Identify reproductive life plan questions and motivational interviewing techniques that are appropriate to efficiently clarify pregnancy intention and reduce patient ambivalence
- List harm reduction strategies for partner treatment notification
- Demonstrate the use of motivational interviewing skills for counseling patients on a variety of health behavior changes

- Apply motivational interviewing techniques to your work in order to maximize rapport and promote healthy behaviors

Who Should Attend?

- Family Planning Staff
- STD and HIV Educators and Testing Staff
- Medical Assistants
- Health Educators
- Social Workers and Counselors
- Nurses
- Clinicians
- Community Health or Outreach Workers
- Any staff who counsel or educate others on health or behavior choices

Register for the LA Workshop: [Click here](#)

Register for the Oakland Workshop: [Click here](#)

WEBINAR: Developments in STI Testing and Implications for Practice

DATE: April 20

TIME: 12:30 ET

In honor of National STD Awareness Month this April, the Maryland Department of Health and Mental Hygiene's Center for STI Prevention (CSIP), along with the STD/HIV Prevention Training Center at Johns Hopkins, invites you to the Seventh Annual Sexual and Reproductive Health Webinar. "Developments in STI Testing and Implications for Practice" will be presented by Dr. Anne Rompalo, Professor of Medicine at the Johns Hopkins University School of Medicine. The webinar will cover the newest advances in STI testing, including point-of-care tests, rapid tests, and extragenital testing.

To [view](#) the webinar, logon [here](#) at 12:30 PM ET on April 20th. For complete details of the webinar, click [here](#).

Job/Internship Postings

Executive Program Analyst – CDPH STDCB

Organization: STD Control Branch, California Department of Public Health

Location: Richmond, CA

JOB OVERVIEW

The Department of Obstetrics, Gynecology & Reproductive Science (OB/GYN & R.S.), SFGH Division is seeking an Executive Program Analyst for its STD Branch contract. The Executive Program Analyst is assigned to the California Department of Public Health (CDPH), Sexually Transmitted Diseases Control Branch (STDCB). This position will be under the general supervision of the Branch Chief. Additionally, this position will work closely with the Chief of the Office of Policy Planning & Communications (OPPC) and the Chief of the Office of Adult Viral Hepatitis Prevention (OAVHP) on programmatic support activities.

The Executive Program Analyst position plays a key role in the STDCB by providing technical, analytical, consultative, and administrative support to Branch staff as a liaison to the Branch Chief position. The individual works closely with all levels of management within the Branch, in addition to managers and chiefs in the Division and Center offices, to support programmatic activities to Branch staff located in Richmond. This position may require light travel within California.

Please Note: This position is located in Richmond, CA.

OBSTETRICS, GYNECOLOGY & REPRODUCTIVE SCIENCE

The mission of the Department of Obstetrics, Gynecology & Reproductive Science (OB/GYN & R.S.) is to promote health and prevent disease in women. We accomplish this by supporting the programmatic initiatives of our faculty and staff in the areas of patient care, education, and research. We are committed to providing quality health care services to all women; educating health care providers and investigators; and conducting research to advance knowledge in our field.

ABOUT UCSF

The University of California, San Francisco (UCSF) is a leading university dedicated to promoting health worldwide through advanced biomedical research, graduate-level education in the life sciences and health professions, and excellence in patient care. It is the only campus in the 10-campus UC system dedicated exclusively to the health sciences.

Required Qualifications

- BA/BS degree with a major in a related field and two years of experience in administrative analysis or operations research; or an equivalent combination of education and experience
- One to two years' work experience in an administrative capacity
- Proficiency in Microsoft Office 2010, including Outlook, Word, Excel, and PowerPoint

Preferred Qualifications

- Experience designing standardized surveys, key informant interviews, or other data collection tools to support formal evaluation
- Experience programming surveys online via Qualtrics, Survey Monkey, or other online survey software
- Experience investigating, collating, and summarizing existing guidelines, regulations, tools, or other resources on a particular public health topic into a useable reference document
- Experience performing quantitative and qualitative data analysis and summarize results
- Experience uploading documents to a web page
- Basic understanding of epidemiology and public health principles
- General knowledge of medical terminology pertaining to sexually transmitted diseases, and appropriate laws, rules, regulations, and policies of the State of California governing the program area(s)
- Ability to juggle multiple priorities and effectively meet deliverables for more than one person/team at time
- Experience collaborating with outside stakeholders in a professional and effective manner
- Experience exercising outstanding initiative, work ethic, and self-motivation
- Proficiency using Microsoft Office 2010, including Outlook, Word, and Excel, PowerPoint
- Knowledge of modern office methods, equipment, and procedures
- Ability to reason logically and creatively
- Ability to work both independently and as part of a team
- Willingness to maintain excellent attendance
- Outstanding organizational and analytical skills; ability to multi-task and work well under pressure

- Experience proofreading, editing, and writing about data in English

**** 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 44432 under 'Req number' to view the posting. Please submit your cover letter and resume electronically to the UCSF Careers website

Peer Advocate - WORLD

Organization: world
Location: Oakland, CA

Summary

WORLD peer advocates mentor women living with HIV/AIDS.

WORLD peer advocates are a part of the WORLD staff and they work in partnership with health care providers who are a part of the Alameda County Family Care Network. By providing information, practical assistance, and emotional support, peer advocates build allied relationships with clients, promoting an ongoing dialogue about HIV-related issues and living with HIV. In addition, peer advocates support clients' efforts to reduce stress and increase quality of life. A peer advocate supports clients' ability to make informed healthcare decisions. Peer Advocates share knowledge about HIV in a non-directive manner, they offer resources and attend appointments with clients to role modeling active communication with physicians. The peer advocate keeps up to date information of current trends to best serve the changing needs of WORLD clients. Under the direct supervision of the Peer Advocate Program Manager, the Peer Advocate will work in cooperation with the peer advocate team and other WORLD staff as needed.

Essential Duties & Responsibilities. Other duties may be assigned.

- Co-facilitates WORLD client support groups as needed.
- Completes written documentation in a timely and efficient manner.
- Provides one-on-one peer counseling at WORLD and other designated sites.
- Helps clients' access services by providing referrals, accompanying to appointments or arranging for transportation.
- Provides non-directive information to clients about HIV disease, treatments, clinical trials, stress reduction and self-care strategies.
- Reminds clients of appointments and follow up after appointments to discuss concerns.
- Provides support and referrals for dealing with difficult issues (disclosure, parenting issues, relationship problems, pregnancy and HIV, substance use, adherence).
- Advocates for clients by bringing concerns to attention of their providers.
- Helps clients identify risk reduction strategies (safer sex, drug treatment, needle exchange, etc.).

Participation in Meetings/Committees

Attends meetings as assigned and/or needed.

Supervisory Responsibilities

This job has no supervisory responsibilities.

Qualifications

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skills, and/or abilities required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience

High school degree or equivalent; first hand knowledge related to HIV/AIDS issues is a plus. Knowledge of harm reduction, healthy coping, and steps for networking with providers preferred.

Computer/Software Skills and Abilities

To perform this job successfully, an individual should have knowledge of Microsoft Word, Excel, Outlook, Power Point and Adobe Acrobat Reader.

Language Skills

Ability to effectively communicate with clients, medical professionals, paraprofessionals, and coworkers. Bilingual Spanish/English a plus.

Other Skills and Abilities/Qualifications

- Sensitivity to issues surrounding HIV and AIDS.
- Ability to work as a team player.
- Strong attention to detail.
- Excellent interpersonal skills.
- Able to work independently and follow established protocols.
- Ability to work with diverse populations.
- Sensitivity to multi-cultural and lifestyle issues.
- Strong organizational/prioritizing skills in a rapidly changing environment.
- Knowledge of harm reduction, health coping, and steps for networking with providers preferred.

Certificates, Licenses and Registrations

- Valid California Driver's License.
- Proof of liability insurance.

Application Procedure

Email resume and cover letter to scornwell@womenhiv.org with the title "Peer Advocate Position" in the subject line of your email. No phone calls please.

For more information: [Click here](#)

Aaron Kavanaugh

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

Tel: 510-231-1773

Fax: 510-620-3180

Web: std.ca.gov

Archives of previous STD Updates can be found [here](#). To unsubscribe or add colleagues' names, email 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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