

[STD Update] FYI 11-24: Pharmacists in CA and OR to prescribe birth control, STD rates hit record high in US, Almost half of US Medicaid recipients denied funding for HCV treatment, 3 papers, 3 jobs, more.

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*Health Program Specialist – CDPH STD Control Branch*

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## **California Stories**

### **Pharmacists in California and Oregon to Prescribe Birth Control**

Alexandra Sifferlin, TIME | 11.23

The laws will be implemented over the next few months.

It will soon be easier for women in California and Oregon to get birth control, as the two states will allow pharmacists to prescribe contraception.

The Seattle Times reports that within the next few months, women will be able to get hormonal contraceptives, like pills and rings from a pharmacist. To get birth control at the pharmacy, women will undergo a brief screening with pharmacists and fill out a questionnaire about their health and medical history.

The laws are extensions of common current practices that allow pharmacists to provide services like vaccinations. In Oregon, teens under 18 must still obtain their contraceptive prescription from a doctor.

“I feel strongly that this is what’s best for women’s health in the 21st century, and I also feel it will have repercussions for decreasing poverty because one of the key things for women in poverty is unintended pregnancy,” State Rep. Knute Buehler, a Republican who sponsored Oregon’s law, told the Times.

Currently about 6.6 million pregnancies in the United States are unintended.

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

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## National Stories

### STD Rates Hit Record High in U.S.

*New federal data shows rates of chlamydia, gonorrhea, syphilis increased significantly in 2014.*

Alexandra Sifferlin, TIME | 11.17

Cases of sexually transmitted diseases (STDs) increased significantly in 2014, according to new data from the U.S. Centers for Disease Control and Prevention (CDC).

The new report shows that cases of chlamydia, gonorrhea, and syphilis have gone up for the first time since 2006. For chlamydia, one of the more common STDs, the CDC reports that 1.4 million cases were reported in 2014, a 2.8% increase in cases from 2013, which represents “the highest number of annual cases of any condition ever reported to CDC.” Each year, more than 70 infectious disease conditions including measles and tuberculosis, are reported to the CDC.

Gonorrhea and syphilis cases also spiked. Syphilis has three stages, and for the first two stages of the infection, the CDC recorded a 15.1% increase in cases from 2013. For gonorrhea, cases have gone up 5.1%.

“America’s worsening STD epidemic is a clear call for better diagnosis, treatment, and prevention,” Dr. Jonathan Mermin, director of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention said in a statement.

Women and young people are the most affected by STDs, according to the CDC, but in 2014 the agency reports that increasing rates in men, including among men who have sex with men, are contributing to the overall uptick. “While anyone can become infected with an STD, certain groups, including young people and gay and bisexual men, are at greatest risk,” the CDC writes in a statement. The agency says the increase in syphilis cases is “alarming,” especially since many cases of chlamydia, gonorrhea, and syphilis go undiagnosed and unreported. Exactly why STDs are increasing isn’t clear, so the CDC is calling

for more research on what's responsible — whether it's lack of awareness or problems with access to testing that is fueling the rise.

In the meantime, the CDC says screening is critical for people who are sexually active. Women under age 25 who are sexually active, or have risk factors like multiple sexual partners, should request yearly chlamydia and gonorrhea tests. Pregnant women should request syphilis, HIV, chlamydia, and hepatitis B tests early in their pregnancy, and gonorrhea tests if they have had recently had multiple sex partners. The CDC recommends that sexually active men who are gay, bisexual, or have sex with men, should get tested for syphilis, chlamydia, gonorrhea, and HIV at least once a year and men at high risk should consider more frequent testing.

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## **People Are Terrified of Sex - At least compared to other risky activities.**

Brian D. Earp, The Atlantic | 11.12

Imagine that a thousand people—randomly selected from the U.S. population—had unprotected sex yesterday. How many of them will eventually die from contracting HIV from that single sexual encounter?

Now, imagine a different thousand people. These people will drive from Detroit to Chicago tomorrow—about 300 miles. How many will die on the trip as a result of a car crash? Which of those two numbers is bigger?

If you're anything like the participants in [a new study](#) led by [Terri D. Conley](#) of the University of Michigan, the HIV estimate should be bigger—a lot bigger. In fact, the average guess for the HIV case was a little over 71 people per thousand, while the average guess for the car-crash scenario was about 4 people per thousand.

In other words, participants thought that you are roughly 17 times more likely to die from HIV contracted from a single unprotected sexual encounter than you are to die from a car crash on a 300-mile trip.

But here's the deal: Those estimates aren't just wrong, they're completely backward.

According to statistics from the U.S. Centers for Disease Control and Prevention and the United States National Highway Traffic Safety Administration, you are actually 20 times more likely to die from the car trip than from HIV contracted during an act of unprotected sex.

Why were the participants' estimates so far off?

Conley and her colleagues think the answer has to do with stigma: Risky behavior related to sex is judged more harshly than comparable (or even objectively worse) health risks, when you control for the relevant differences between the behaviors.

“It seems that as a culture we have decided that sex is something dangerous and to be feared,” Conley told me in an interview. That’s why, she argues, U.S. parents try to “micromanage” their children’s sexuality, “with the danger of STIs [Sexually Transmitted Infections] being a large part of that.”

At the same time, “parents are excited about kids getting their driver's licenses, and do not regularly forbid their child from driving ... they know there are risks but assume the kids must learn to manage those risks.”

She thinks this approach should be applied to sex as well.

Of course, there could also be a moralistic aspect here—a kind of hangover from America’s Puritan founding. I raised this possibility with Shaun Miller, a philosopher at Marquette University who focuses on love and sexuality. “I’m not sure if it relates to our Puritan values,” he told me, “but I do think the stigma is a proxy for moral judgment. Sexuality has always had to do with one's moral character, and so if one has an STI, it suggests that one's character is ‘infected’ as well.”

To test this idea that sex-related risks are more stigmatized than other types of risk, Conley and her colleagues ran a follow-up study. In the study, they wanted to control for some of the differences between driving cars and having sex—two activities that both carry risk, sure, but which are different in other ways.

If these differences could somehow explain the weird estimates that participants gave in the first study—without having anything to do with sex-related stigma, specifically—it would undermine Conley’s theory.

Conley and her team designed a test that would compare “apples to apples”—two cases where a health threat was transmitted through sex, but only one of which was an actual STI.

They gave a collection of 12 vignettes to a large number of participants—one vignette per person. All of the vignettes told the same basic story: Someone transmits a disease to someone else during a casual sexual encounter, without knowing that they had something to transmit. There were two diseases: either chlamydia, a common STI that rarely causes serious health problems (and that can be completely cured with a course of antibiotics), or H1N1—commonly known as the swine flu—which can be seriously bad for your health or even kill you.

The main thing they manipulated between the different vignettes was the severity of the outcome caused by the disease. A “mild” outcome was described as getting sick enough to have to see the doctor, and then take a week’s worth of medicine. A “moderate” outcome was the same, except that you had to go to the emergency room first. A “serious” outcome was getting hospitalized and nearly dying. And a “fatal” outcome was, well, dying.

The last two conditions only applied to H1N1, because chlamydia rarely gets that bad.

Once the participants read their vignette, they had to say what they thought about the person who transmitted the disease. The participants would rate the person on how risky and how selfish their behavior was, as well as how dirty, bad, and immoral, and dumb they were for doing what they did.

The results were surprising. Participants who read the story about someone unknowingly transmitting chlamydia—with a “mild” outcome—judged that person more harshly than participants who read about the swine-flu case where the other person actually died!

Even Conley didn't expect to see this. “Why would there be so much culpability surrounding a ‘sex disease’ but not a non-sexual disease transmitted through sex?” she said.

It's a good question. Unjustified stigma about STIs—Conley's preferred explanation—could be one answer. But there's another possible answer as well, and it's one that points to a potential weakness in the methodology of this second study.

There's an important difference between chlamydia and swine flu in terms of how you can prevent them from being transmitted, and it has to do with condoms. Using a condom will dramatically reduce your chances of transmitting an STI like chlamydia, but it would have no effect on transmitting the swine flu. This is because swine flu isn't passed on through genital contact, but rather through the respiratory system (so you could get it through kissing, or coughing).

So participants who were given the “chlamydia” vignette might have reasoned something like this. “If the person in this story had made sure that condoms were being used—which is the responsible thing to do in a casual sexual encounter—then the STI would very likely not have been transmitted. But it was transmitted. So the person was probably not using condoms. I'm going to rate this person harshly now, because I disapprove of this irresponsible behavior.”

Similarly, as the philosopher and cognitive scientist Jonathan LaTourelle of Arizona State University pointed out to me, “people might think that if you have chlamydia there is at least some probability you have it because of some prior sexual behavior that they disapprove of as well.”

In the swine-flu case, the same kind of judgment just couldn't apply. That's because even if safe-sex strategies were being employed, the virus would transmit exactly the same.

To their credit, Conley and her colleagues acknowledged this limitation in their paper, earning praise from other researchers I talked to. But limitations aside, Conley's team thinks their study has important implications for public health. The main one, in their view, is that the stigma surrounding STIs needs to be drastically reduced. Otherwise, they fear, it could backfire, leading to more STI-transmission, not less.

“The basic research on stigma is quite clear on one issue,” Conley and her colleagues write in the paper. “Stigmatizing behaviors does not prevent unhealthy activities from occurring. For example, the more individuals experience stigma associated with their weight, the less likely they are to lose weight.”

So, they conclude, “we have every reason to suspect that stigmatizing STIs will [likewise] be associated with poorer sexual-health outcomes.”

They give two examples to illustrate this risk. One: If someone thinks they might have an STI but worries that their doctor will stigmatize them, they might be less likely to seek medical treatment. And two: If someone thinks their potential sexual partner will judge them for having an STI, then they'll be less likely to bring it up.

But it might not be that simple. Stigmatizing some behaviors (like overeating) doesn't seem to reduce them, but what about other behaviors—like smoking? There is some evidence, though it is contested, that increasing stigma around smoking actually has been pretty effective in reducing the number of smokers over time. When it comes to stigmatization, then, the question is whether risky sex is more like smoking, or more like overeating.

As the scientific cliché has it, “more research is needed.”

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## **Preventive HIV Medicine PrEP Could Keep New Diagnoses Low Among High-Risk Groups, Says Study**

Ed Cara, Medical Daily | 11.16

In 2012, the Food and Drug Administration (FDA) approved the first medication strictly intended for the purpose of reducing the risk of contracting HIV among uninfected high-risk individuals — a practice known as preexposure prophylaxis (PrEP).

Though PrEP is believed to be highly effective, there have been questions as to how feasible a treatment it might be outside of the laboratory, particularly because these drugs need to be taken on a nearly-daily basis (4 or more times a week). Others have voiced concerns that PrEP may actually encourage unsafe sexual behaviors like condomless sex or forgoing regular STD testing. The results of a three-year-long study published this Monday in *JAMA Internal Medicine*, however, offers encouraging support for PrEP as a means of HIV prevention in the real world, though not without some caveats.

### **The Importance Of Adherence**

The study authors observed 557 men who have sex with men (MSM) and transgender women in three different cities, San Francisco, Miami, and Washington, D.C., as they were given the chance to receive PrEP free-of-charge via their community health provider (which included STD clinics) for 48 weeks. They found that the rate of new HIV infections among those who remained on PrEP was drastically low for the entirety of the study, while the relatively high rate of other STDs and unsafe sexual behaviors remained stable.

All told, of the 437 participants who received PrEP for the full 48 weeks, only two actually came down with HIV infection, both in the follow-up period after the treatment was discontinued (that period ended in February 2015). They were identified as having low levels of the drug tenofovir diphosphate, part of the PrEP cocktail, at the time of their infection. While these are laudable results, it should be noted that 21.5 percent of the group didn't stick around for the duration of the study, indicating that there might be difficulties in maintaining complete PrEP adherence, even with better than normal economic conditions. The authors themselves note that poor insurance coverage may restrict access to PrEP in a real world setting.

Additionally, though 80 to 85 percent of those tested (294) had levels of medication sufficient to protect themselves, African American men, widely considered the highest risk group, were the least likely to effectively adhere to the PrEP regimen, as were participants at the Miami STD clinic. On the other hand, the authors did find those with the most risky behaviors, such as condomless anal sex and a large

number of sex partners, were also the most likely to stick to their regimen. Having a stable housing situation predicted treatment adherence as well, leading the researchers to conclude, “Interventions that address racial and geographic disparities and housing instability may increase the impact of PrEP.”

In an accompanying editorial by Dr. Raphael J. Landovitz, a member of the UCLA Center for Clinical AIDS Research & Education in California, he similarly expressed guarded optimism over the study’s findings.

Noting the clinics (and their employees) in the study are “well-versed in PrEP science, well-rooted in community activities, and experienced with behavioral and biomedical HIV prevention strategies,” Landovitz worried that it might be difficult to generalize their results to less motivated and knowledgeable treatment sites. “Overall the news concerning PrEP dissemination is good but there are sobering lessons,” he wrote.

**Source:**

Liu A, Cohen S, Vittinghoff E, et al. Preexposure Prophylaxis for HIV Infection Integrated With Municipal- and Community-Based Sexual Health Services. *JAMA Internal Medicine*. 2015

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

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## **Almost half of US Medicaid recipients denied funding for hepatitis C treatment, 4-state study shows**

Keith Alcorn, [aidsmap.com](#) | 11.17

Around one in six people with hepatitis C in four US states had their prescriptions for direct-acting antivirals refused by insurers, and almost half of Medicaid recipients were denied reimbursement in 2014 and early 2015, a study by the University of Pennsylvania has found. The findings were presented on Monday at the 2015 AASLD Liver Meeting in San Francisco.

Restrictions on Medicaid funding of direct-acting antiviral treatment by state governments in the United States has led the Centers for Medicare & Medicaid Services to write to state Medicaid directors to remind them that they are expected to cover new interferon-free antiviral therapies for hepatitis C without undue restrictions.

Access to direct-acting antiviral treatment may be restricted by insurers through medical criteria – such as restricting treatment to people with advanced fibrosis – or by applying requirements such as abstinence from alcohol or injecting drug use. Insurers may also delay decisions on treatment, potentially risking a worsening of liver damage or even death.

The extent to which insurers – including the Medicare system of publicly-funded insurance for over-65s and the Medicaid publicly-funded system for people on low incomes – restrict access to hepatitis C treatment was investigated by researchers from University of Pennsylvania, led by Assistant Professor of Medicine Vincent Lo Re. The researchers were particularly interested to find out whether Medicaid recipients faced greater difficulties in obtaining approval for treatment.

The study used data supplied by Burman’s pharmacy, looking at all hepatitis C medication prescriptions in four states – Delaware, Maryland, New Jersey and Pennsylvania – between 1 November 2014 and 30 April 2015. The researchers evaluated what proportion of prescriptions submitted for insurer approval

by the pharmacy were refused, the reason for refusal and how long it took for prescriptions to be approved. These outcomes were assessed according to the type of insurer (private insurance, Medicare for over-65s and the disabled, and Medicaid for people with low-income or special needs).

During the study period 2321 people presented prescriptions for direct-acting antivirals which were subsequently submitted to an insurer and were eligible for analysis. The study excluded people with genotypes 4-6, people whose medication had already been authorised prior to the pharmacy visit, uninsured people or those who were not permitted to use Burman's Pharmacy by their insurer. The majority of people presenting prescriptions were covered by Medicare (800) or Medicaid (517); 1025 people were privately insured. Most Medicaid recipients were receiving care through a Medicaid-approved managed care plan.

Unsurprisingly, Medicare recipients were significantly older than other insurance groups, and Medicare and Medicaid recipients were more likely to be African-American (29% and 33% respectively, compared to 21% of privately insured,  $p < 0.001$ ), and to have cirrhosis (35% and 32% respectively, compared to 26% of the privately insured).

The vast majority of prescriptions were for sofosbuvir/ledipasvir (Harvoni) (80% of Medicaid and 86% of other insured persons) or for sofosbuvir (Sovaldi)/ribavirin (11% of Medicaid).

Overall, 16.2% of prescriptions were refused. Recipients of Medicaid were significantly likely to be refused – 46% of Medicaid recipients were refused reimbursement, compared to 5% of Medicare recipients and 10% of the privately insured. Medicaid recipients were ten times more likely to be refused reimbursement when compared to the privately insured.

Of those refused, lack of data to determine medical need was the most common reason, accounting for almost half of all Medicaid refusals. Around one-third of Medicaid denials were on the grounds of lack of medical need. In comparison, half of all privately insured patients who were denied treatment were refused on the grounds of lack of medical need.

In each insurance category a disturbing proportion of patients refused treatment received no formal letter of denial, and the insurer did not bother to respond. Approximately one in seven Medicaid recipients who failed to receive insurance authorisation received no letter informing them that their prescription had been denied.

Drug and alcohol use were not major reasons for denial. Around 5% of Medicaid recipients were denied treatment on these grounds, compared to 10% of privately insured patients. However the researchers emphasised that they lacked information on drug or alcohol history, and that this information might be a confounding factor.

People without cirrhosis were significantly more likely to be denied treatment (adjusted odds ratio 2.85), as were people who presented prescriptions before 31 January 2015 (aOR 3.16).

People insured by Medicaid had to wait significantly longer than others for their prescription to be approved – a median of 24 days compared to 14 days for others ( $p < 0.001$ ), and a quarter had to wait over 49 days.

Denial of treatment and delays in treatment are likely to result in worse outcomes, the investigators warned.

**Reference:**

Lo Re V et al. Incidence and determinants of denial of DAA therapy by type of insurance during the first six months of the modern HCV treatment era. AASLD Liver Meeting, San Francisco, abstract LB-5, 2015.

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

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## **New HCV Combo Beats Standard Care**

*Cures 95% of difficult to treat patients*

Michael Smith, Medpage Today | 11.17

An investigational drug combination for hepatitis C (HCV), shown to work extremely well in most patients, did almost as well in the most difficult to treat population, a researcher said here.

In the phase III ASTRAL-3 trial, 12 weeks of therapy with the combination of sofosbuvir (Sovaldi) and velpatasvir led to cures in 95% of patients with HCV genotype 3, according to Alessandra Mangia, MD, of the Casa Sollievo della Sofferenza Hospital in San Giovanni Rotondo, Italy.

That was significantly better than the 80% rate seen among patients given standard therapy -- 24 weeks of sofosbuvir and ribavirin, Mangia reported at the annual meeting of the American Association for the Study of Liver Diseases and simultaneously online in the New England Journal of Medicine.

Another study, ASTRAL-2 -- reported here separately but combined with ASTRAL-3 in the journal report -- found that just 12 weeks of treatment was enough to yield a cure rate of 99% among patients with HCV genotype 2.

The two studies were reported just a day after researchers reported striking results in a phase III trial, ASTRAL-1, in patients with genotypes 1, 2, 4, 5, and 6.

In that study, 99% of patients were cured, where a cure was defined (as in all the studies) as a serum HCV RNA level of less than 15 IU per ml measured 12 weeks after the end of therapy -- the so-called SVR12.

The maker of the drugs, Gilead Sciences, had originally planned just two trials -- ASTRAL-1 and a separate ASTRAL-3 study in genotype 3 patients that would have an active comparator because of the challenges involved in treating that population.

But while ASTRAL-1 was enrolling patients, including some with genotype 2, the FDA asked for a separate trial with an active comparator in genotype 2, which was dubbed ASTRAL-2.

All the trials have "excellent safety and efficacy," commented John Ward, MD, and Jonathan Mermin, MD, both of the CDC.

In an accompanying editorial, they noted that the combination seemed to work regardless of the viral subtype, the treatment history of the patient, or the degree of liver damage caused by HCV.

Such "simple, safe, and curative HCV therapies" could have profound public health implications for the estimated 150 million people around the world with the disease, they said.

Current HCV therapies -- many almost as effective -- require genotyping and disease staging before starting treatment, a level of care that most patients don't get. The sofosbuvir-velpatasvir regimen could reduce the need for these steps, "paving the way for simple 'test and cure' strategies," Ward and Mermin argued.

However, a big issue now is ensuring access to the medications: "Patients do not benefit from a drug they cannot afford," Ward and Mermin wrote.

The two drugs target different aspects of HCV replication. Sofosbuvir is a nucleotide analogue NS5B polymerase inhibitor, approved to treat HCV genotypes 2 and 3 in combination with ribavirin. Velpatasvir is a new NS5A inhibitor.

Both ASTRAL-2 and -3 enrolled treatment-naïve and -experienced patients, including those with compensated cirrhosis.

In the ASTRAL-3 study, Mangia reported, investigators treated 552 patients, randomly assigned to get the investigational combination for 12 weeks or standard therapy for 24 weeks.

Some 264 of 277 patients on the novel combination achieved SVR12, compared with 221 of 275 getting standard care -- a difference that was significant at  $P < 0.001$ .

Eleven patients in the sofosbuvir-velpatasvir arm had relapsed after the end of treatment, and two were lost to follow-up. On the other hand, 38 of the sofosbuvir-ribavirin patients relapsed, one had virologic failure during treatment, six were lost to follow-up, four stopped therapy because of adverse events, two withdrew consent, two died, and one discontinued treatment before achieving undetectable HCV RNA.

Six patients treated with sofosbuvir-velpatasvir reported a serious adverse event, as did 15 patients on sofosbuvir-ribavirin, Mangia reported. There were no deaths in the investigational arm and three among those getting sofosbuvir-ribavirin, including one from gunshot wounds and two whose cause was not known.

Outcomes in the ASTRAL-2 trial, reported here by Mark Sulkowski, MD, of Johns Hopkins University in Baltimore, were similar to those seen in the ASTRAL-1 study.

The investigators treated 266 patients, again randomly assigned to get one or the other combination, but in this case all participants were treated for 12 weeks.

They reported that 133 of 134 patients on the novel combination reached SVR12, compared with 124 of 132 getting standard care, a difference that was significant at  $P = 0.02$ .

None of the patients getting sofosbuvir-velpatasvir relapsed, although one man discontinued study treatment after receiving one dose of the study drug because of anxiety, headache, and difficulty concentrating.

On the other hand, six patients on sofosbuvir–ribavirin relapsed and two were lost to follow-up.

Two patients on sofosbuvir-velpatasvir died during follow-up, one from cardiac arrest 131 days after the end of treatment and one from complications of metastatic lung cancer 112 days after the end of treatment.

#### **Primary Source**

New England Journal of Medicine

#### Source Reference:

Foster GR, et al "Sofosbuvir and velpatasvir for HCV genotype 2 and 3 infection" *N Engl J Med* 2015; DOI: 10.1056/NEJMoa1512612.

#### **Secondary Source**

New England Journal of Medicine

#### Source Reference:

John Ward, et al "Simple, effective, but out of reach? Public health implications of HCV drugs" *N Engl J Med* 2015; DOI: 10.1056/NEJMe1513245.

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

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## **The health app that hopes to empower women**

Jenny Gering, BBC News | 11.18

The contraceptive pill revolutionised sexual and social behaviour in the 1960s.

Today's revolution for women is knowing exactly when to expect your period, according to Ida Tin, co-founder and chief executive of the reproductive health tracking app Clue.

Although Clue is not recommended as a contraceptive, the app tracks a woman's cycle, and can predict, not only fertility and menstruation, but also related symptoms such as mood swings or PMS (premenstrual syndrome).

As is the case with many good business ideas, Ms Tin's inspiration came from personal experience.

"Our reproductive health is an incredibly foundational and central part of our lives," she says.

"I was around 30 and I wasn't on the pill, because it didn't work that well for me. I was wondering why nobody had built a really good tool to manage this part of life."

She adds: "Clue is all about empowering women. It allows women to make better individual health decisions, and to improve their overall well-being."

Ms Tin, 36, knows from experience how empowering it can be, for a woman, to take things into her own hands.

Before she founded Clue in Berlin in 2012, she spent five years running a business in her native Denmark which organised motorcycle tours around the world.

Ms Tin also wrote a best-selling book about her motorcycling exploits in far flung parts of the planet.

### **Financial backing**

Ms Tin runs Clue with her co-founder and partner Hans from an open plan loft office in the German capital.

Although the business is only three years old, more than two million women in over 180 countries now use Clue, which Ms Tin says is the world's fastest-growing menstrual cycle tracking app.

She says: "We don't have a typical app user. It is a group as diverse as women are on this planet.

"A lot of girls and women are using Clue because they want to know themselves and their bodies better.

"Some women are using Clue because they're trying to get pregnant, others to get reminders to take their birth control pills, or to share their data with a doctor."

The app is free - and hasn't made the company any money yet.

However, Ms Tin hopes that it will start to generate revenue within the next few years, and is continuing to explore the best ways of doing so.

She appears to have the confidence of her investors, as Clue recently raised \$7m (£4.6m) of funding from venture capital firms Union Square Ventures, which is based in New York; and London's Mosaic Ventures. This brings the total Clue has secured to \$10m.

The cash is being used to expand Clue's team of 22 full-time staff, develop new features for the app and increase the number of users.

### **'Company's responsibility'**

Clue is the latest addition to an increasingly crowded market place. So the search is on for ways of distinguishing itself from the competition.

Right from the start Ida was determined that the app should not be "pink" or "girly".

So the design is gender neutral - and the company is at great pains to stress the scientific nature of the way the app works.

Users have to regularly enter information into a calendar. Topics range from menstruation to motivation, and from sex drive to appetite.

According to the company, the more information you put into the app the more accurate it is. And the firm works closely with doctors and reproductive health scientists to ensure that accuracy.

When it comes to the daily running of the business, Ms Tin encourages staff to work flexibly, so as to balance their work and family lives.

"Reaching the right balance between family and work is not only a personal responsibility and choice for both women and men." she says. "It's also a company's responsibility."

The needs of Ms Tin's two children are built into her busy daily schedule. She drops her five-year-old son Elliot at kindergarten each morning, before bringing her one-year-old daughter Eleanor to the office.

Ida happily describes the toddler as an "office baby".

"It's not always easy to balance a family and a company" she says, "but I'm a very stubborn person and I am just not willing to have to choose between the two.

"It has to be possible to have a family and work on something I deeply care about."

On the day that the latest tranche of money from investors hits the company's account, there's a quiet celebration in the office.

Ms Tin is clearly excited about what the money means for the future of her young company.

"I want to build a platform for women's health data," she says, "so women can get deep insights about their body."

She raises a glass of champagne in thanks to her staff, her daughter Eleanor cradled in one arm.

There's a real symbolism to the moment - a woman with big hopes for the future, balancing her twin loves - her family and her business.

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## Scientific Papers/Conference Abstracts

### **An outbreak of high-level azithromycin resistant *Neisseria gonorrhoeae* in England**

Chisolm SA, Wilson J, Alexander S, et al. *Sex Transm Infect* 2015; [Epub ahead of print]  
doi:10.1136/sextrans-2015-052312

#### **Objectives**

To investigate a potential outbreak of high-level azithromycin resistant (HL-AziR) gonococcal infections diagnosed in eight patients attending a sexual health clinic in Leeds, North England, between November 2014 and March 2015.

#### **Methods**

Eight cases of infection with gonococci exhibiting azithromycin minimum inhibitory concentrations (MICs)  $\geq 256$  mg/L were identified from patients in Leeds as part of the routine service provided by the Sexually Transmitted Bacteria Reference Unit. All patient records were reviewed to collate

epidemiological and clinical information including evaluation of patient management. Whole-genome sequencing (WGS) was performed on seven gonococcal isolates to determine *Neisseria gonorrhoeae* multiantigen sequence type (NG-MAST), WGS comparison and mutations in the 23S rRNA genes.

### Results

All patients were heterosexual (five male, three female) from a range of ethnic backgrounds and from the Leeds area. Three patients were linked by partner notification. All patients were infected at genital sites and two women had pharyngeal infection also. Six patients received the recommended first-line therapy for uncomplicated gonorrhoea, one was treated for pelvic inflammatory disease and one received spectinomycin followed later by ciprofloxacin. Test of cure was achieved in seven patients and confirmed successful eradication. All seven isolates sequenced were identical by NG-MAST and WGS comparison, and contained an A2143G mutation in all four 23S rRNA alleles.

### Conclusions

Epidemiological and microbiological investigations confirm that an outbreak of a gonococcal strain showing HL-AziR is ongoing in the North of England. Every effort should be made to identify and curtail dissemination of this strain as it presents a significant threat to the current recommended front-line dual therapy.

View the paper online: [Abstract](#)

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## Condom deserts: geographical disparities in condom availability and their relationship with rates of sexually transmitted infections

Shacham E, Nelson EJ, Schulte L, et al. *Sex Transm Infect* 2015; [Epub ahead of print]  
doi:10.1136/sextrans-2015-052144

### Background

Identifying predictors that contribute to geographical disparities in sexually transmitted infections (STIs) is necessary. This study assesses the spatial relationship between condom availability to locations of STIs in order to better understand these geographical disparities.

### Objectives

We conducted a condom availability audit among potential condom-selling establishments. New gonorrhoea and chlamydia cases in 2011 (n=6034) and HIV infection cases from 2006 to 2011 (n=565) were collected by census tract in St Louis, Missouri. 829 potential condom-selling establishments participated in the condom availability audit in St Louis City; 242 of which sold condoms.

### Results

A negative linear relationship exists between condom vendors and cases of gonorrhoea and chlamydia, after adjusting for concentrated disadvantage and free condom locations. Higher concentrated disadvantage, higher proportions of convenience vendors and free locations were associated with higher rates of HIV.

### Conclusions

This study was conducted to provide evidence that lack of condom availability is associated with STI rates, and likely is an integral component to influencing the subjective norms surrounding condom use

and STI rates. Condom distribution interventions may be addressing availability needs and social norms, yet are more likely to be effective when placed in locations with the highest STI rates.

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

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## **Per capita incidence of sexually transmitted infections increases systematically with urban population size: a cross-sectional study**

Patterson-Lomba O, Goldstein E, Gomez-Lievano A, et al. *Sex Transm Infect* 2015;91:610-614

### **Objectives**

Rampant urbanisation rates across the globe demand that we improve our understanding of how infectious diseases spread in modern urban landscapes, where larger and more connected host populations enhance the thriving capacity of certain pathogens.

### **Methods**

A data-driven approach is employed to study the ability of sexually transmitted diseases (STDs) to thrive in urban areas. The conduciveness of population size of urban areas and their socioeconomic characteristics are used as predictors of disease incidence, using confirmed-case data on STDs in the USA as a case study.

### **Results**

A superlinear relation between STD incidence and urban population size is found, even after controlling for various socioeconomic aspects, suggesting that doubling the population size of a city results in an expected increase in STD incidence larger than twofold, provided that all other socioeconomic aspects remain fixed. Additionally, the percentage of African-Americans, income inequalities, education and per capita income are found to have a significant impact on the incidence of each of the three STDs studied.

### **Conclusions**

STDs disproportionately concentrate in larger cities. Hence, larger urban areas merit extra prevention and treatment efforts, especially in low-income and middle-income countries where urbanisation rates are higher.

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

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## **Resources, Webinars, & Announcements**

### **White House Unveils the Theme for World AIDS Day 2015**

The U.S. government announced that the theme for this year's World AIDS Day (WAD) is "The Time to Act Is Now."

Observed on December 1, which falls on a Tuesday this year, WAD is a time to recommit to fighting the epidemic and achieving an AIDS-free world.

“This year, we will celebrate the tremendous progress we have made together in expanding access to HIV prevention, treatment, and care services, and focus on the potential to achieve sustainable epidemic control and end AIDS as a public health threat,” reads a [White House statement](#) by Douglas M. Brooks, MSW, the director of the Office of National AIDS Policy, and Ambassador Deborah L. Birx, MD, the U.S. global AIDS coordinator and special representative for global health diplomacy.

“In 2015,” the statement continues, “we know what it takes to prevent HIV infections and improve the lives of people living with HIV, and we are building on the success of the U.S. President’s Emergency Plan for AIDS Relief, the release of the United States’ National HIV/AIDS Strategy: Updated to 2020, and our commitment to the Sustainable Development Goals. ‘The Time to Act Is Now’ looks to the future and demonstrates the urgent need for action today.”

Follow World AIDS Day on social media—and join the conversation—with the hashtag #WAD2015.

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

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## **PleasePrEPMe.org makes it easier to find nearest California PrEP provider**

Press Release

Finding the nearest health provider willing to prescribe you pre-exposure prophylaxis (PrEP) just got easier in California. With individuals looking to renew or change their insurance plans during open enrollment season, PleasePrEPMe.org, a searchable location-based PrEP provider directory website, launched to remove PrEP access barriers and take the guess work out of figuring whether a provider is knowledgeable about PrEP or not.

“While there is increasing ‘demand’ for PrEP with more and more people asking about it in the community, we need to do a better job to address the ‘supply’ side of the equation and make it easier to deliver PrEP services to the individuals who want and need them,” said HIVE Director Shannon Weber. “It’s extremely rewarding to be able to empower people in this capacity and increase their access to PrEP as an HIV prevention option, especially with the continued rollout of the Affordable Care Act and more people enrolling in health plans.”

Even though there is an ever-growing body of research proving PrEP effectively reduces the risk of HIV infection for HIV-negative individuals by more than 90 percent when taken daily, uptake of PrEP is not widespread. Recent modeling shows only one-third of eligible HIV-negative individuals living in San Francisco is taking PrEP and increased access to PrEP could curb the local HIV epidemic.

PleasePrEPMe.org connects users interested in taking PrEP to willing providers with its unique searchable location-based capabilities. After entering a user’s location, the website scans the directory of more than 180 PrEP providers to list and map the nearest PrEP providers within a 30 mile radius. The website also offers resources for patients to learn more about PrEP and how to pay for it, as well as provider to increase their capacity to include PrEP in their practice.

California PrEP providers are encouraged to add their location to the directory if they haven’t already done so. By early 2016, the goal is to register at least one PrEP provider from the state’s 58 counties. To date, the directory includes nearly half.

PleasePrEPMe.Org was produced by HIVE with support from Gilead and is a collaboration between partners in the San Francisco Bay Area, Los Angeles and San Diego counties to unify the various regional lists of PrEP providers in the state.

For more information, visit [www.PleasePrEPMe.org](http://www.PleasePrEPMe.org). Join the conversation with #PleasePrEPMe.

#### **About HIVE**

After over 20 years as leaders in prenatal, pre-conception and women's HIV care, BAPAC (Bay Area Perinatal AIDS Center) has evolved HIVE. With our compassionate, evidence-based, woman-centered model of care, there have been no cases of perinatal HIV transmission in San Francisco in over a decade. Building on this success, we are expanding our scope to comprehensive reproductive and sexual health among those affected by HIV. For more information, visit [www.hiveonline.org](http://www.hiveonline.org).

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

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## **Job/Internship Postings**

### **Communicable Disease Control Program Supervisor – San Mateo County Health System**

**Organization:** San Mateo County Health System  
**Location:** San Mateo, CA  
**Salary:** \$6,718 - \$8,398 /Month  
**App. Deadline:** December 10

#### **THE POSITION**

The San Mateo County Health System is seeking a well-qualified individual for the position of Communicable Disease Control Program Supervisor to assist in the development and implementation of goals and objectives; direct and evaluate Communicable Disease Control Program activities; oversee operational needs of program; and supervise program staff.

The current vacancy is in the Public Health, Policy and Planning Division located in San Mateo, but will travel throughout the County to perform duties of the job.

Primary duties will include:

- Assist in the development and implementation of goals, objectives, policies and procedures for the Communicable Disease Control Program.
- Assess, direct, monitor and evaluate Communicable Disease Control Program activities in accordance with best practices, including quality assurance and improvement.
- Oversee daily operational needs of the Communicable Disease Control Program, including problem resolution and establishing systems to ensure smooth functioning.
- Plan, organize, assign, review, evaluate and direct the work of Communicable Disease Control Program public health nurses and communicable disease investigators. Provide feedback and corrective action as indicated, in conjunction with the Health Services Manager.
- Monitor staff caseloads and productivity to ensure equitable work assignments.

- Oversee and monitor communicable disease data reporting by staff into the online disease reporting database, CalREDIE, in conjunction with the Communicable Disease Controller and Epidemiology Program.
- Interpret technical updates, standards, policies, procedures and other guidance documents to Communicable Disease Control Program staff, in conjunction with the Communicable Disease Controller and Health Services Manager.
- Participate in the selection and hiring of Communicable Disease Control Program personnel and provide for their training and professional development, in conjunction with the Health Services Manager.
- Facilitate problem solving of communicable disease control issues with providers, colleagues, community partners and the general public, in conjunction with the Communicable Disease Controller.
- Maintain established standards of public health communicable disease control and ensure that services are rendered in conformance with policy and procedural guidelines.
- Provide oversight and supervision of communicable disease case/contact and outbreak investigations per the San Mateo County Communicable Disease Manual and other established public health protocols.
- Participate in committees, meetings, advisory panels and working groups pertaining to communicable disease control and public health measures, in order to establish effective working relationships and necessary program linkages.
- Facilitate technical and informational presentations regarding communicable disease and public health to professional and community groups.
- Assist the Communicable Disease Controller with the development and dissemination of critical public health messages pertaining to communicable disease control including alerts, exposure notices, advisories and press statements to the medical community, public/private sector organizations, the media and general public as warranted.
- Oversee the maintenance and updating of the San Mateo County Communicable Disease Manual on a regular basis as needed, in conjunction with the Communicable Disease Controller.
- Supervise Communicable Disease Control Program "Officer of the Day" information, referral and consultation duties provided by staff to inquiries from the medical community and general public. Provide perspective and guidance to staff when warranted.
- Identify staff development needs and facilitate continuing staff education and professional development.
- Perform related duties as assigned.

The **ideal candidate** will possess the following:

- Extensive knowledge of Communicable Disease Control.
- Experience supervising staff, assigning duties and tasks, and conducting performance evaluations.
- Experience leading a team of staff whose work assignments are in the field of Communicable Disease Control areas.
- Masters in Public Health or related field.
- Familiarity with the laws, rules, regulations and procedures governing the Communicable Disease Control.
- Demonstrated skill to organize and be able to plan and implement various service activities under the Communicable Disease Control Program.
- Ability to analyze and problem solve exercising sound judgment in decision-making.
- Ability to establish and maintain effective working relationships.
- Experience as a representative or liaison of their organization.

- Excellent communication skills both verbal and written.

**NOTE: The eligible list generated from this recruitment may be used to fill future extra-help, term, unclassified, and regular classified vacancies.**

### **Qualifications**

**Education and Experience:** Any combination of education and experience that would likely provide the required knowledge, skills and abilities is qualifying. A typical way to qualify is a Bachelor's degree from an accredited college or university in public administration, health care administration, a social science or a field related to the program area to which assigned; and six years of increasingly responsible or supervisory work in the delivery of community, health or social services which has included responsibility for programmatic development such as planning, evaluating, monitoring or coordinating projects, and supervising or leading support staff.

**Knowledge of:** Principles and practices of Communicable Disease Control; principles and practices of employee supervision and training; principles and practices of program planning, research and evaluation and contract monitoring and compliance; specialized technical knowledge related to Communicable Disease Control; principles and practices of client service delivery; contemporary social, political and economic trends and problems related to community services; principles of engaging community and other partners in the provision of public health services; applicable federal, state and local laws, rules and regulations and County and program policies and guidelines; computer applications related to the work; office administrative practices and procedures, including records management and the operation of standard office equipment; basic budgetary and financial record-keeping techniques; and community resources, organizations and programs.

**Skill/Ability to:** Plan, assign, supervise, review and evaluate the work of others; train staff in work procedures and provide technical and programmatic assistance to staff and subcontractors; administer and coordinate programs services and activities; foresee and analyze operational and/or administrative problems, consider alternatives and recommend sound solutions; supervise the development and evaluation of proposals and negotiation of contracts and agreements; develop, monitor and analyze program performance goals; analyze, interpret and apply various regulations and requirements; communicate effectively in writing and orally and make public presentations; prepare clear, concise reports, correspondence and recommendations; analyze information and situations and use sound independent judgement to make decisions and determine appropriate courses of action; and establish and maintain effective and cooperative working relationships with those contacted in the course of the work.

### **Application/Examination**

**Anyone may apply.** Current San Mateo County and San Mateo County Superior Court employees with at least six months (1040 hours) of continuous service in a classified regular, probationary, SEIU or AFSCME represented extra-help, or temporary position prior to the final filing date will receive five points added to their final passing score on this examination. Responses to the supplemental questions must be submitted in addition to our regular employment application form.

The examination will consist of an interview (weight: 100%). Depending on the number of applicants, an application appraisal of education and experience may be used in place of other examinations or a screening committee may select those applicants whose education and/or experience appear to best

meet the needs of the position based solely on the information provided in the application documents. Because of this screening process, all applicants who meet the minimum qualifications are not guaranteed advancement to the next phase of the examination process.

**IMPORTANT: Applications for this position will only be accepted online.** If you are currently on the County's website, you may click the 'Apply Now' button above. If you are not on the County's website, please go to <http://jobs.smcgov.org> to apply. Online applications must be received by the Human Resources Department before midnight on the final filing date.

~ TENTATIVE RECRUITMENT SCHEDULE ~

**Final Filing Date: DECEMBER 10, 2015**

**Application Screening: DECEMBER 15, 2015**

**Combined Panel/Department Interviews: JANUARY 5 and/or 6, 2016**

Effective July 1, 2014, the County of San Mateo will no longer require job applicants to disclose conviction history information until after the applicant successfully completes all examination phases for the recruitment. All passing applicants will receive instructions by email only from Human Resources staff to complete and submit a conviction history questionnaire online within a specified deadline of two business days. Failure to do so within the timeframe will disqualify you from the rest of the process. Please visit this link at <http://hr.smcgov.org/conviction-information-applicants-faq> to find out more information about the conviction history questionnaire so that you can prepare accordingly.

**Note:** Positions in criminal justice agencies currently required by law to pass background checks are exempted from this bill, and applicants may be required to submit conviction information at the time of application.

**San Mateo County is an Equal Opportunity Employer**

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

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## **STD/HIV Community Outreach Worker (Spanish Speaking Required) – San Mateo County Public Health Services**

**Organization:** San Mateo County Public Health Services

**Location:** San Mateo County, CA

**Salary:** \$3,809.87 - \$4,761.47 Monthly

**App. Deadline:** December 10

### **Description:**

The STD/HIV Program of the San Mateo County Public Health Services has an immediate opening for STD/HIV Community Outreach Worker-Spanish Speaking Required (Community Worker II). The current vacancy is in the HIV Prevention Unit and the position will work as part of a team to provide STD/HIV outreach, education, and testing to communities at increased risk for sexually transmitted infections, HIV, and Hepatitis C disease. CWs provide outreach to high-risk populations from a variety of sexual and drug using behaviors, life experiences, backgrounds, ethnicities, cultures, and socio-economic backgrounds, e.g., injection drug users (IDUs), men who have sex with men (MSMs), transgender individuals, sex workers, homeless, migrant workers, etc. Work is performed (days, nights and weekends when necessary) in areas where these communities congregate or can be reached; such as bars, parks,

adult bookstores, sex cruising areas, alcohol and drug recovery programs, correctional facilities, community fairs, low-income neighborhoods, etc.

The STD/HIV CW will provide both field and site-based STD/HIV outreach, education, and testing as needed in the mobile HIV testing van, satellite sites, or via testing on demand. Some of the primary duties of the STD/HIV Community Outreach Worker include, but are not limited to the following:

- With a team of outreach workers, provide on-the-street HIV prevention education to individuals at high risk for HIV from drug-use, sexual behaviors, or other risky behaviors.
- Provide outreach in target communities in which people reside or congregate.
- Work non-traditional hours that are based on the needs of the target communities.
- Identify areas of the county where high-risk groups congregate and build rapport with the communities.
- Screen clients' risks for HIV, Hepatitis C and Syphilis, and encourage testing as appropriate.
- Maintain all necessary documentation of services and submit reports in a timely manner.
- Drive a 30-foot mobile testing van.

The **ideal candidate** for this position:

- Is self-motivated;
- Has at least two years of experience providing outreach and counseling for HIV/AIDS prevention in a variety of communities similar to the County;
- Can work comfortably with diverse populations in a non-judgmental manner;
- Is certified as an HIV Test Counselor utilizing finger-stick procedures for specimen gathering;
- Is a certified Phlebotomy Technician;
- Has a good knowledge of STDs, HIV, and Hepatitis C disease, transmission, and prevention;
- Has strong oral communication and documentation skills;
- Has used bilingual Spanish speaking skills to engage and assist clients; and
- Is compassionate, a team worker and has excellent interpersonal skills.

**NOTE:** The eligible list generated from this recruitment may be used to fill future extra-help, term, unclassified, and regular classified vacancies.

### **Qualifications**

**Language Requirement:** Ability to speak, read, and write fluently in both English and Spanish.

**License:** Valid driver's license. Ability and willingness to drive large van is also necessary.

**Experience and Education:** Any combination of education and experience that would likely provide the required knowledge and skills is qualifying. A typical way of gaining the knowledge and skills is two years of experience which has involved providing outreach, educating and testing for STDs and HIV.

**Knowledge of:** STDs, HIV and Hepatitis C transmission, primary and secondary prevention methods, course of infection and treatment; behavior change, harm-reduction and outreach techniques; substance use/abuse, recovery and treatment issues; high-risk groups described above; diverse cultural values; and medical, social service and other community resources available.

**Skill/Ability to:** Identify and work in communities with the greatest risk for STD/HIV infections; work non-traditional hours, including evenings and weekends or other times based on the characteristics of the target population; relate to and communicate effectively with the targeted population; refer clients to appropriate community resources; function as a team member; exercise good judgment and tact; compile concise and accurate data, in a timely manner, regarding the client populations and services

performed; and stand and walk for extended periods of time and lift and carry equipment and supplies used in the course of the work.

Application/Examination

**Anyone may apply.**

**Responses to the supplemental questions must be submitted in addition to our regular employment application form. All applications will be screened for completeness and relevancy of education and/or experience to the needs of the position. Only those applicants who are screened in are moved through the examination process as described below.**

The examination process will consist of a scored relevant Training and Experience (T & E) evaluation (weight: 100%) based solely on the candidates' responses to the supplemental questions. Depending on the number of applicants, an application appraisal of education and experience may be used in place of other examinations. Because of this screening process, all applicants who meet the minimum qualifications are not guaranteed advancement to the next phase of the examination process.

Candidates who receive a passing score in the Training and Experience evaluation will be placed on an eligible list grouped by level of qualifications. The top level candidates will be the first group offered an opportunity to interview with the hiring department. All examinations will be given in San Mateo County, California and applicants must participate at their own expense.

**IMPORTANT: Applications for this position will only be accepted online.** If you are currently on the County's website, you may click the 'Apply Online' button above or below. If you are not on the County's website, please go to <http://jobs.smcgov.org> to apply. Online applications must be received by the Human Resources Department before midnight on the final filing date.

~ TENTATIVE SELECTION SCHEDULE ~

**Final Filing Date:** DECEMBER 10, 2015

**Training and Experience Evaluation:** WEEK OF DECEMBER 14, 2015

Effective July 1, 2014, the County of San Mateo will no longer require job applicants to disclose conviction history information until after the applicant successfully completes all examination phases for the recruitment. All passing applicants will receive instructions by email only from Human Resources staff to complete and submit a conviction history questionnaire online within a specified deadline of two business days. Failure to do so within the timeframe will disqualify you from the rest of the process. Please visit this link at <http://hr.smcgov.org/conviction-information-applicants-faq> to find out more information about the conviction history questionnaire so that you can prepare accordingly.

**Note:** Positions in criminal justice agencies currently required by law to pass background checks are exempted from this bill, and applicants may be required to submit conviction information at the time of application.

**San Mateo County is an Equal Opportunity Employer**

HR Contact: Yvonne Alvidrez (112015) (Community Worker II - G113)

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

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## Health Program Specialist – CDPH STD Control Branch

**Organization:** California Department of Public Health, STD Control Branch  
**Location:** Richmond, CA  
**Salary:** \$5,053.00 - \$6,325.00  
**App. Deadline:** December 5

### Description:

The California Department of Public Health (CDPH), Sexually Transmitted Diseases Control Branch (STDCB) is recruiting for a Health Program Specialist I (HPS I). If you are interested in a challenging and exciting work environment and are ready to work with an energetic team of professionals, this is an excellent opportunity to apply.

This position requires the incumbent maintain consistent and regular attendance, communicate effectively (orally and in writing if both appropriate) in dealing with the public and/or other employees, develop and maintain knowledge and skill related to specific tasks, methodologies, materials, tools and equipment, complete assignments in a timely and efficient manner, and adhere to departmental policies and procedures regarding attendance, leave, and conduct.

### Job Summary:

Under the direction of the Staff Services Manager II, Business Operations Support Section, the Health Program Specialist I (HPS I) will serve as the primary point of contact for local health jurisdictions (LHJs), including grants and contract management functions. The HPS I will provide leadership and technical assistance to the LHJs, community-based organizations (CBOs), and others in establishing robust linkage to care networks as part of a state-funded hepatitis C testing and linkages to care demonstration projects initiative. The HPS I will provide support to LHJs, municipalities, regional entities, private businesses, volunteer organizations, and state agencies to ensure these organizations meet the goals, objectives, and benchmarks as outlined in the state-funded Hepatitis C testing and linkages to care demonstration projects initiative.

### Required Statement of Qualifications:

In order to be considered for this position, interested candidates must submit a Statement of Qualifications. Resumes in lieu of a Statement of Qualifications will not be considered. **Applications received without a response to each question in the statement of qualifications will not be considered.**

When responding to the questions, applicants must follow these guidelines:

- Responses must be typewritten or generated by word processing on 8-1/2 x 11 paper, using no smaller than an 11-point font.
- Responses should be no longer than a total of two pages, single spaced, with 1 inch margins.
- Answer each numbered item separately indicating the corresponding item number for each response.
- Identify each page with your full name and position number.
- Ensure your responses are complete, specific, clear, and concise.

- 1. Please provide an example from your work experience that demonstrates your ability to juggle several tasks and keep track of multiple deadlines at one time. What was your strategy? How did you overcome challenges? What was the outcome?**
- 2. Describe a situation where you successfully built effective working relationships with key internal and/or external stakeholders (e.g. senior management, vendors, etc.) in order to accomplish an important result. What did you do? What was the result?**
- 3. Describe your most recent project/assignment failure. What was the reason for the undesirable outcome or mistake? What were the lessons learned to make a successful or better outcome in the future?**

**Who May Apply:** Qualified candidates, who have list eligibility for State employment, are in a reachable rank on a certification list for the HPS I classification, former State employees who are eligible to reinstate into this classification, and employees currently in this classification who have transfer eligibility. Employees applying for this position who wish to be considered on a transfer basis must meet the minimum qualifications for the classification per California Code of Regulations Rule 250. You may be required to provide copies of your college transcripts or a copy of your college diploma if applicable. If you have SROA/Surplus status, please indicate by attaching your SROA/Surplus letter and note it on line 12 of your application.

If you are interested in the position, please submit a completed state application (STD 678) to the address listed below. Your original signature on your application certifies under penalty of perjury that the information is true and complete to the best of your knowledge. Therefore, emailed or faxed copies will not be accepted. Applications must be postmarked by the final filing date in order to be considered for this vacancy. Applications will be screened and only the most qualified candidates will be selected for an interview. The State of California is an equal opportunity employer to all, regardless of age, ancestry, color, disability (mental and physical), exercising the right to family care and medical leave, gender, gender expression, gender identity, genetic information, national origin, political affiliation, race, religious creed, sex (includes pregnancy, childbirth, breastfeeding and related medical conditions), and sexual orientation.

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

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**Aaron Kavanaugh**  
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