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## **California Stories**

### **STD cases reaching all-time highs in U.S., California**

Soumya Karlamangla, Los Angeles Times | 11.19

Much to the worry of public health officials, new data show that cases of chlamydia, gonorrhea and syphilis in California have reached an all-time high.

A report released this week from the U.S. Centers for Disease Control and Prevention shows that rates of these three sexually transmitted diseases have been steadily increasing in the state since 2010, while national rates sometimes stayed flat or even fell. In 2014, the rates for the diseases were higher in the Golden State than in the nation overall.

Nationally, rates of these three diseases have fluctuated over the last five years, but all three surged in 2014. The center called the increases “alarming.”

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

The volume of chlamydia cases last year was particularly staggering. Nationwide, there were about 1.4 million cases, which is the highest number of annual cases of any condition ever reported to the CDC.

The new data also show that among the more than 3,000 counties in the nation, Los Angeles County had the most cases of all three diseases in 2014. That's partly because it's home to more people than any other county.

In 2014, there were 456 cases of chlamydia in the U.S. per 100,000 people, compared with 460 cases in California and 548 cases in L.A. County. The nation saw 111 cases of gonorrhea per 100,000 people that year, compared with 119 cases in the state and 153 cases in the county. The county’s cases of primary and secondary syphilis were double the U.S. rate, with six cases in the nation per 100,000 people, 10 cases in the state and 12 cases in L.A. County.

Compared with other states, California had the 22nd-highest rate of chlamydia, the 15th-highest rate of gonorrhea and the fourth-highest rate of primary and secondary syphilis.

According to state data, L.A. County’s rates of chlamydia and gonorrhea are among the top six of the state’s 58 counties. San Francisco, Kern and Fresno counties have higher rates of both diseases.

“STDs are a substantial health challenge facing the United States,” a CDC report summary says. “Each of these infections is a potential threat to an individual’s immediate and long-term health and well-being.”

Chlamydia and gonorrhea are common and curable diseases, but if not treated can cause serious problems such as infertility in women. Officials estimate that undiagnosed STDs cause 20,000 women in the country to become infertile each year.

More than half of chlamydia and gonorrhea cases occur among people ages 15 to 24. Officials recommend that sexually active women younger than 25 be tested annually for these diseases.

Syphilis, which is also curable, can lead to complications such as blindness if allowed to progress. It has been of particular concern recently in California, where early cases of the sexually transmitted disease among women more than doubled from 248 to 594 from 2012 to 2014.

That has led to a worrisome increase in cases of congenital syphilis, in which a mother infects her child during pregnancy. From 2012 to 2014, those cases shot up dramatically to 100 from 30. Most of the congenital cases occurred in Los Angeles County and the Central Valley, according to state health officials.

Stillbirths caused by syphilis in California also rose, to six cases in 2014 from one case in 2012.

Health officials recommend using condoms during sex to prevent the spread of these diseases.

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

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## **STDs mostly increase in county, nation**

*Health experts are especially concerned about pregnant women passing on diseases to their kids*

Paul Sisson, The San Diego Tribune | 12.11

Gonorrhea and syphilis rates continue to rise in San Diego County, and public-health officials are keeping an especially close eye on the small but growing number of pregnant women at risk of passing sexually transmitted diseases to their unborn children.

New data from the U.S. Centers for Disease Control and Prevention show that an ongoing increase in STD rates nationwide continued in 2014. Experts point to a range of factors driving the increases, from limited funding for intervention programs to dating apps that make traditional anti-STD outreach methods less effective.

Last year, the national rate of chlamydia infection was 456 cases per 100,000 residents, the highest recorded by the CDC since 1984, the first year that records are available for this disease. San Diego's chlamydia rate topped the nation's last year, but actually decreased compared to the figure from 2013.

Local cases of syphilis showed a 24 percent year-over-year increase from 2013 to 2014, according to the CDC. Gonorrhea rates in the county also jumped 21 percent during the same period.

Women have historically contracted syphilis at much lower rates than men, and that was still the case last year. But the number of confirmed syphilis cases are increasing more quickly in women than they are in men, and more expectant mothers are passing on their infections to their children before birth.

That trend is particularly troubling to the public-health community.

"The overall syphilis epidemic has grown and grown and is now affecting more women. We also saw 100 congenital (syphilis) cases in 2014. That was nearly a doubling in one year," said Dr. Heidi Bauer, chief of the STD Control Branch at the California Department of Public Health.

Experts said congenital syphilis is a strong warning signal about challenges with public-health surveillance and treatment because the condition is 100 percent preventable if women are treated with penicillin before giving birth.

Left untreated, syphilis can cause a host of severe health effects. It starts with unexplained sores and rashes and can progress to paralysis, blindness, internal organ damage and death. The disease is linked

with higher rates of premature birth and stillbirth, and untreated children often develop problems in multiple organs.

There were six stillbirths due to the disease last year in California, Bauer said, adding that the patients involved tend to share certain characteristics.

“The cases we’re seeing tend to be among women who are fairly poor and have poor access to health services. In general they’re very marginalized, often in homeless populations,” she said.

The state’s highest rates of congenital syphilis last year were reported in regions such as Fresno, Inyo, Kern and Imperial counties. While San Diego’s rate was lower than the statewide average, local public-health officials have still taken notice.

Dr. M. Winston Tilghman, the STD controller for San Diego County, said his office reviews every case of congenital syphilis and does outreach to urge that pregnant women in high-risk groups get tested for the disease at least once during their pregnancy — and to be tested as soon as possible.

“We’re definitely giving women of child-bearing age top priority. We are concerned about this trend, and it’s something we’re definitely monitoring closely,” Tilghman said.

He said there is work to be done not just in initial screening efforts but also in follow-up testing for at-risk women in their third trimester of pregnancy if they have moved on to a new relationship or if they are known to have multiple sexual partners. He also noted that an initial test result showing no syphilis does not ensure that the disease will not be contracted later if the expectant mother subsequently engages in unsafe sexual activity.

“We need to make sure that our health-care providers out there in the communities know how to manage syphilis,” Tilghman said.

Meanwhile, the county recently implemented the “Don’t Think, Know” program, which sends a free testing kit to interested women’s homes, allowing them more convenience because they do not have to visit one of the county’s STD clinics or go to a doctor’s office. The program is on hiatus due to technological issues, but is expected to resume in January.

Congenital syphilis is viewed by the public-health community as something of a canary in the coal mine, said Dr. Jeffrey Klausner, a professor of medicine and public health at the UCLA David Geffen School of Medicine.

“It’s really a marker of a failed public health system, because congenital syphilis is completely preventable. It means that the systems, like access to adequate prenatal care, are not working,” said Klausner, who has analyzed and written about STD prevention efforts.

As to why San Diego County and the nation have seen a multi-year trend of generally rising STD rates, Klausner pointed to funding cuts for prevention programs enacted in 2008 as a primary driver.

“The funding is always chasing the rates of STDs. Rates go down, funding goes away. Rates increase, funding goes up,” Klausner said.

California's health officials said state funding for anti-STD programs have stayed flat since 2007.

Klausner said if agencies and nonprofit groups manage to secure more money for their STD projects, it will not be enough to beef up programs that have existed for decades, especially those that ask young people to visit their doctors and get tested.

Today's teenagers and young adults are living much more connected lives than they were even five years ago, he said. Increasingly, sexual partners are being discovered through dating apps on smartphones. This immediacy, Klausner said, creates impatience with STD testing, which can take a week to provide results.

He recently returned from London, where he said he saw the future of public health: a clinic equipped with touch-screen computers and rapid-testing equipment.

"You just enter your information into a touch-screen computer, duck into a restroom to provide a urine sample, hand it over and you've got your results in a text message within six hours," Klausner said.

He noted that research is also being conducted on ways to securely store test results on smartphones, where they can be shared with potential partners more conveniently. These types of strategies are sorely needed in America's most technologically savvy state, he said.

"We could do a lot better in California by bringing some of these tools forward," Klausner said.

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

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## **SF plan to end HIV shows progress**

Liz Highleyman, The Bay Area Reporter | 12.3

San Francisco made good progress in HIV prevention and treatment during 2015, and its successes have brought the city national and worldwide attention. But more work is needed to "get to zero," especially in reaching currently underserved groups.

"Like Silicon Valley in the tech world, San Francisco is where innovation happens in the HIV world," Dr. Diane Havlir, chief of the HIV/AIDS division at San Francisco General Hospital, said at a December 1 forum commemorating World AIDS Day.

Havlir and committee members from the city's Getting to Zero Consortium gave a progress report on the initiative, which aims to make San Francisco the first U.S. jurisdiction to eliminate new HIV infections, HIV-related deaths, and HIV stigma and discrimination.

"Highlights of this year's accomplishments include a substantial increase in PrEP uptake, launch of a citywide protocol to ensure immediate access to care and treatment for people newly diagnosed with HIV, and the beginning of a comprehensive program to increase retention in care for everyone living with HIV," Dr. Susan Buchbinder, director of Bridge HIV at the San Francisco Department of Public Health, told the Bay Area Reporter. "In 2016, we'll build upon these early successes, with a particular focus on populations in greatest need."

In an update to the SF Health Commission, Buchbinder reported that the number of newly diagnosed HIV infections in the city fell by more than 18 percent, from 371 in 2013 to 302 in 2014 - the lowest since the start of the epidemic. The number of new infections fell in all racial/ethnic groups and only 14 women were newly diagnosed last year. Deaths due to any cause among people with HIV fell by 15 percent during the same period, from 209 to 177.

### **Plan has three parts**

Getting to Zero relies on a three-pronged strategy of expanded access to pre-exposure prophylaxis (better known as PrEP), rapid access to antiretroviral therapy (ART), and retention of HIV-positive people in care.

PrEP - use of antiretroviral drugs to prevent HIV from taking hold in the body after exposure - saw the most dramatic and highly publicized advances over the past year.

Data continued to accumulate confirming the effectiveness of PrEP both in clinical trials and in real-world use. Researchers reported this year that daily PrEP in the English PROUD study and intermittent or "on demand" PrEP in the French Ipergay study both reduced the risk of HIV infection by 86 percent.

A trio of PrEP demonstration projects in San Francisco, Miami, and Washington, D.C. found that no one who took PrEP regularly became infected. And no new infections have been seen so far among more than 650 mostly gay and bisexual men who received PrEP at Kaiser Permanente San Francisco.

The Food and Drug Administration approved Gilead Sciences Truvada (tenofovir/emtricitabine) for PrEP in 2012, but adoption was initially slow. While there has been an upsurge in the number of people taking PrEP over the last two years, experts agree that it is probably too soon for it to have been a major factor in the decline of new infections in 2014.

The consortium's PrEP committee reported that as of November 2015 a total of 3,854 people in San Francisco were known to be taking PrEP. This includes 1,366 people seen at SF General Hospital, UCSF, the SF Veterans Affairs Medical Center, and Kaiser Permanente; 779 seen at SF City Clinic and the SF AIDS Foundation's Magnet clinic; and 1,709 seen by private doctors and medical groups. But this is an underestimate, as it does not include other community health centers, some large hospitals, and many private providers.

Limited available data indicate that a majority of PrEP users are white gay and bisexual men in their mid-30s. Experts have estimated that between 10 and 15 percent of gay men in the city who are eligible for PrEP are currently taking it.

In an effort to expand access - and to reach out to other groups - the consortium has started a "PrEP ambassador" program in which volunteers promote PrEP awareness in their communities. In addition, local agencies have used city funding to hire "navigators" to help people gain access to Truvada and determine how to pay for it.

"Our work in San Francisco continues to be a model for how to scale up pre-exposure prophylaxis," PrEP researcher Dr. Robert Grant from the UCSF Gladstone Institutes told the B.A.R.

### **Getting and keeping people in care**

One factor that likely has had an impact on the recent reduction in new HIV infections and deaths is early antiretroviral treatment.

In 2010 San Francisco was the first city to recommend antiretroviral therapy for everyone diagnosed with HIV regardless of CD4 T-cell count. U.S. treatment guidelines adopted the same recommendation in 2012, and the World Health Organization did so this year.

Findings from the large START trial reported this year showed that starting treatment soon after diagnosis significantly lowers the risk of illness and death for people with HIV. And final data from the HPTN 052 study confirmed that HIV-positive people on treatment with an undetectable viral load have very low likelihood of transmitting the virus.

San Francisco continues to lead the way with its RAPID program, which aims to get people diagnosed with HIV on treatment as soon as possible, ideally the same day. Early data from a pilot program at SF General Hospital showed that 90 percent of eligible patients opted to start treatment on the day of their first visit. RAPID participants reached undetectable viral load in 56 days on average - less than half the time it took for those receiving standard care.

The Getting to Zero RAPID committee has developed a protocol for accelerated treatment that has been adopted at SF City Clinic and Kaiser Permanente, with a goal of expansion to all public and private providers citywide.

"RAPID is all about getting to zero delay in antiretroviral treatment," RAPID researcher Dr. Christopher Pilcher from UCSF told the B.A.R.

But people with HIV must remain in care to get the maximum benefit in terms of improved health and reduced transmission. Retention is the third pillar of the city's Getting to Zero effort - and it may be the most difficult.

Socioeconomic issues are the "Achilles heel of retention," according to retention committee co-chair Andy Scheer. Many people with HIV who drop out of care are dealing with unstable housing or homelessness, mental health issues, and drug or alcohol use.

"San Francisco's crisis of housing affordability and shortage of mental health and substance use services severely jeopardizes patients attempting to remain in care and be virologically suppressed," Scheer stressed. "Retention is a monster that requires a huge amount of time and money."

### **Funding adds up**

To date San Francisco has devoted \$1.2 million in city funds to Getting to Zero efforts. This includes \$300,000 in PrEP funding from the Board of Supervisors requested by gay District 9 Supervisor David Campos; that money is currently making its way through a Request for Proposals process and the DPH is negotiating with top-scoring applicants.

In late October the city announced that it received a grant of \$500,000 from the MAC AIDS Fund to support retention in care. In addition, the Centers for Disease Control and Prevention has awarded San

San Francisco \$1.9 million over three years for PrEP expansion and another \$958,000 to develop ways to identify people who drop out of care and bring them back in.

Following a model established in the early years of the epidemic, San Francisco relies on community-based organizations that can reach the most heavily affected groups, including young gay and bisexual men, communities of color, transgender people, and sex workers.

"We don't believe in doing things top-down here," said gay District 8 Supervisor Scott Wiener. "The reason San Francisco has had so much success is not because city government says 'this is what we're going to do,' but because of an amazing coalition of community-based advocates."

A number of local agencies, including the San Francisco AIDS Foundation, GLIDE, St. James Infirmary, and API Wellness Center, have received funding to advance the goals of the Getting to Zero strategy. Much of that money will go towards navigators to assist HIV-negative people in accessing and paying for PrEP and to help HIV-positive people get linked to care and stay on treatment.

San Francisco's position as potentially the first city to end the epidemic was highlighted in several major media stories this year. Mayor Ed Lee joined the Fast-Track Cities Initiative, collaborating with mayors and city governments from more than 50 cities with a high burden of HIV. UNAIDS executive director Michel Sidibé visited San Francisco this summer to observe some of its pioneering programs.

"Because the city has spent decades focused on meeting the human needs of marginalized communities, Getting to Zero's focus on the rapid scale-up of proven biomedical interventions is working," SFAF's James Loduca said at a World AIDS Day event this week at the White House. "Innovation is fundamental, but innovation alone doesn't get the job done. Progress also requires compassion, collaboration, and community action."

Even as San Francisco leads the way in HIV prevention and treatment, it is also on the cutting edge of research towards a cure.

On November 30 amfAR announced that it had selected UCSF to host a new Institute for HIV Cure Research. The new initiative launched with an initial \$20 million grant, which amfAR CEO Kevin Frost said was "a floor, not a ceiling."

"It's a nice bookend with the Getting to Zero initiative in that San Francisco seeks to be in the lead in ending the epidemic by applying treatment as public health and by fundamental research," Dr. Paul Volberding, director of UCSF AIDS Research Institute and the new cure institute told the B.A.R. "That's more or less the story of our response to HIV/AIDS from the beginning - it's amazing to think of where we were and how far we've come."

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

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## National Stories

### Drug resistance acquired during HIV PrEP rapidly disappears after medication is discontinued

Michael Carter, [aidsmap.com](http://aidsmap.com) | 12.14

Drug resistance acquired in rare cases of HIV infection during treatment with pre-exposure prophylaxis (PrEP) rapidly disappears once medication is discontinued, investigators report in *AIDS*. Use of ultra-sensitive tests performed six months after seroconversion and discontinuation of PrEP failed to find any resistant virus.

“Multiple studies have now shown that the risk of developing resistance from PrEP is very low, but is an important concern for those who initiate PrEP during unrecognized acute infection,” comment the authors. “Our data show that resistance selected in these cases decays rapidly to levels below detection of even highly sensitive assays.”

PrEP with emtricitabine/tenofovir (Truvada) or tenofovir (Viread) alone is highly effective at preventing infection with HIV. However, resistance to these antiretroviral drugs has been detected in individuals who initiated PrEP during unrecognized acute HIV infection, and, very rarely, in patients infected with HIV while taking PrEP.

Such resistance could limit future HIV treatment options. It is therefore important to determine if it persists once treatment is withdrawn. To answer this question, investigators from the Partners PrEP study designed a longitudinal study involving nine patients who had drug-resistant HIV (K65R, K70E, and/or M184V mutations) detected during HIV seroconversion. Archived blood samples were tested to see if resistance was transmitted or acquired because of PrEP. Ultra-sensitive assays were used to monitor for resistant strains of virus six, twelve and 24 months after cessation of PrEP.

Archived blood samples which were HIV RNA-positive, antibody-negative were available prior to seroconversion for four of the nine patients. None of these patients had resistance mutations prior to seroconversion, suggesting that resistance was acquired due to PrEP therapy rather than being transmitted.

PrEP was stopped immediately on the detection of seroconversion. Ultra-sensitive assays were used to see if resistance persisted after PrEP was withdrawn.

Levels of resistant virus had decayed – or fallen – to below the limit of detection in all patients six months after treatment was discontinued and remained undetectable twelve and 24 months after follow-up.

“PrEP-selected resistance decays rapidly after PrEP cessation,” comment the investigators. “By six months after seroconversion (after PrEP was discontinued), resistance mutations K65R, K70E and/or M184V that were present at seroconversion were no longer detected, even with highly sensitive resistance testing.”

Only one patient started antiretroviral treatment (ART) within 40 months of seroconversion. This patient initiated therapy at month 33, taking a combination of nevirapine/emtricitabine/tenofovir. Viral load

was approximately 19,000 copies/ml. Three months after starting ART, this patient had an undetectable viral load.

The investigators call for future studies to examine whether PrEP-associated resistance affects subsequent response to treatment.

**Reference:**

Weis JF et al. Preexposure prophylaxis-selected drug resistance decays rapidly after drug cessation. *AIDS* 30: 31-35, 2015.

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

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## Health ads on social media reach Rhode Island MSM

John Schoen, *Healio Infectious Disease News* | 12.11

An estimated one in four Rhode Island gay, bisexual and other men who have sex with men viewed health prevention banner ads on online dating apps and “clicked through” to the state’s health department website, where they could access information regarding sexually transmitted diseases and HIV clinical services.

“With the widespread use of cellphone apps and other technology, the Internet has become a popular choice among gay, bisexual and other MSM for meeting partners,” Thomas E. Bertrand, MPH, chief of the Office of HIV/AIDS, Viral Hepatitis, STDs and TB at the Rhode Island Department of Health, told *Infectious Disease News*.

In Rhode Island, syphilis cases increased among MSM from 52 cases in 2013 to 80 cases in 2014, according to researchers. Approximately one in three of these cases were HIV-positive, they said. From 2013 to 2014, HIV cases in this population also increased — from 40 cases to 56 cases. According to interviews conducted with MSM diagnosed with HIV in 2014, more than 90% indicated that they met their sexual partners through social networking websites and geo-targeted smartphone apps.

Although research focusing on the impact of social media on STD rates is lacking, a 2014 study by Chan and colleagues suggests the introduction of Craigslist was related to an average 15.9% increase in reported HIV cases over a 10-year period across 33 states. This translates to a yearly estimate of 94 new infections per state, 6,130 to 6,455 new cases nationally, and \$62 million to \$65.3 million in treatment costs.

As part of a new statewide project, Bertrand and colleagues developed a custom Web page on the Rhode Island Department of Health (RIDOH) website, called “Sexual Health Information for Gay Men.” The page includes information about STD and HIV prevention and links to both testing services and a separate website — [www.Men2Menri.org](http://www.Men2Menri.org) — designed to help men find “gay-friendly doctors” in the state, according to the researchers.

The project also included a 6-week paid advertising campaign. According to Bertrand, focus groups were used to develop the ads and campaign message, which were displayed on several online dating websites and apps such as Grindr, and linked to the custom RIDOH website. Emails directing MSM to the RIDOH website also were used in the campaign.

Immediately following the campaign's launch, the custom Web page became one of the top 10 most visited pages on the RIDOH website, netting an average of 206 page views per day, the researchers said. A large majority (approximately 92%) of the Web traffic comprised mobile phone users. The researchers observed spikes in traffic as the public health ads appeared across the various dating websites. In addition, [www.Men2Menri.org](http://www.Men2Menri.org) experienced a 125% increase in visits during the campaign.

Compared with the average 2-month period before the campaign began, there was a "substantial increase" in the number of patients visiting STD clinics in Rhode Island — from 13 to 23 — who cited the RIDOH as their referral source, according to Bertrand and colleagues. The researchers estimated that approximately 20% to 30% of MSM in the state viewed a campaign banner ad on the targeted dating websites and clicked through to the RIDOH website.

"Creating trust with gay, bisexual and other MSM patients who have a STD, and understanding how they meet their partners, is essential for ensuring treatment of partners and preventing reinfection among patients," Bertrand said.

#### References:

Bertrand T, et al. Abstract 1232. Presented at: National HIV Prevention Conference; Dec. 6-9, 2015; Atlanta.

[Chan J, et al. \*MIS Quarterly\*. 2014;38:955-976.](#)

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

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## An increase in alcohol tax appears to have decreased gonorrhea rates in Maryland by 24 percent

Elizabeth Hillaker Downs, UF News | 12.9

Increasing state alcohol taxes could help prevent sexually transmitted infections, such as gonorrhea, according to University of Florida Health researchers, who found that gonorrhea rates decreased by 24 percent in Maryland after the state increased its sales tax on alcohol in 2011.

Multiple prior studies have shown that increases in alcohol taxes decrease alcohol consumption. Less drinking reduces risky sexual behavior, such as having unprotected sex or having sex with new partners. In 2014, the rate of infection from gonorrhea, chlamydia and syphilis increased substantially nationwide, and young people accounted for nearly two-thirds of the cases of gonorrhea and chlamydia. This UF Health study is one of the first to quantify the effect of alcohol taxes on the rate of sexually transmitted infections.

"If policymakers are looking for methods to protect young people from harmful STIs, they should consider raising alcohol taxes, which have decreased remarkably over the years due to inflation," said Stephanie Staras, Ph.D., MSPH, an assistant professor in the UF College of Medicine department of health outcomes and policy and the study's lead researcher.

Sexually transmitted diseases can cause pain, infertility and certain types of cancer. In Maryland, the tax increase resulted in 2,400 fewer statewide cases of gonorrhea during the 18 months after the tax

increase went into effect, according to findings published today (Dec. 9) in the American Journal of Preventive Medicine.

The tax increase in Maryland was only \$0.03 per \$1. The tax increased from 6 percent, which had been the sales tax rate on alcohol since July 1, 2008, to 9 percent on July 1, 2011.

The team used data from the National Notifiable Disease Surveillance System, which includes all state and local reports of select nationally notifiable diseases from public and private sources, for 102 months prior to the tax increase and 18 months after the tax increase.

To attribute the effects the team observed to the increase in alcohol taxes, the researchers compared the trends in sexually transmitted diseases in Maryland with three groups of other states. First, the researchers compared Maryland with those states that have a similar alcohol sales method but did not increase alcohol taxes and do not share a border with Maryland: California, Arizona, Colorado, Indiana, Wisconsin, New Mexico, Texas, North Dakota, South Dakota, Oklahoma, Louisiana, Florida and Rhode Island. To compare Maryland to states with similar trends in sexually transmitted diseases, the team compared rates in Maryland with the states with the most similar baselines, which was Oklahoma for chlamydia and Colorado for gonorrhea. To account for potential regional contributions to sexually transmitted disease trends, the team also compared Maryland with Rhode Island. The rate of gonorrhea infections decreased an additional 24 percent in Maryland compared with these control states after the increased tax went into effect.

The research team did not find any effect on chlamydia rates or any differences across age, race or ethnicity, or gender. This lack of difference across various demographics suggests the tax may have influenced all individuals similarly, Staras said.

The lack of effect on chlamydia rates could be due to the fact that chlamydia infections are more likely to be asymptomatic or mild compared with gonorrhea, which means people are less likely to seek testing and therefore the cases are less likely to be reported. In addition, gonorrhea infections are more geographically concentrated and restricted to higher-risk populations, magnifying the influence of small changes, such as a decrease in alcohol consumption. High-risk populations include individuals who engage in risky sexual behavior with concurrent partners or those who have sexual partners within an interconnected social group.

“Right now, the only population-level intervention for STIs recommended by the Centers for Disease Control and Prevention is condom distribution,” Staras said. “However, the effects we observed in this study are comparable to the effectiveness of condom distribution, and taxes generate revenue rather than spend it — making it a powerful option for policymakers to consider.”

This research was supported by the Zanyvl and Isabelle Krieger Fund via a grant to the Johns Hopkins Bloomberg School of Public Health, which provided the research team at the UF College of Medicine a sub-grant to conduct this research.

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## Grazoprevir/elbasvir cures more than 90% of people with HIV/HCV co-infection

Liz Highleyman, aidsmap.com | 12.11

Merck's grazoprevir/elbasvir combination cured 93% of people with HIV and hepatitis C co-infection, was well-tolerated and did not appear to interact with antiretrovirals, according to final results from the C-EDGE Co-infection study presented at the 2015 AASLD Liver Meeting last month in San Francisco. These results confirm that people with HIV/HCV co-infection respond as well to interferon-free therapy as those with HCV alone.

About one-third of people with HIV worldwide are thought to be co-infected with hepatitis C virus (HCV). Over years or decades chronic hepatitis C can progress to serious liver disease including cirrhosis and liver cancer. People with HIV/HCV co-infection have faster liver disease progression than those with HCV alone, on average, and liver disease is a leading cause of death among people living with HIV. While people living with HIV do not respond as well to interferon-based hepatitis C treatment, there is growing evidence that this is not the case for new direct-acting antiviral agents used in interferon-free regimens.

Jürgen Rockstroh of Bonn University in Germany presented final results from the phase 3 C-EDGE Co-infection study, which tested the NS3/4 protease inhibitor grazoprevir and NS5A inhibitor elbasvir in a fixed-dose co-formulation. Results were previously presented in part at this year's EASL International Liver Congress and published in the August 2015 edition of *The Lancet HIV*.

Grazoprevir/elbasvir is undergoing US Food and Drug Administration review with a decision expected in January 2016.

C-EDGE Co-infection included 218 previously untreated participants with HIV/HCV co-infection in Europe, the US and Australia with HCV genotypes 1a (66%), 1b (20%), 4 (13%) or 6 (1%). More than 80% were men, 77% were white, 17% were black and the mean age was 49 years. The median baseline CD4 T-cell count was 568 cells/mm<sup>3</sup> and 16% had liver cirrhosis.

Participants could either be untreated for HIV with a CD4 count above 500 cells/mm<sup>3</sup> (3%) or on stable antiretroviral therapy (ART) with more than 200 cells/mm<sup>3</sup> and undetectable HIV RNA (97%). Antiretrovirals permitted in this study were raltegravir (Isentress; 52%), dolutegravir (Tivicay; 27%), or rilpivirine (Edurant; 17%); 75% used tenofovir (Viread, also in Truvada) and 22% used abacavir (Ziagen, also in Kivexa or Epzicom) as a NRTI backbone.

All participants in this open-label trial received grazoprevir/elbasvir in a once-daily single-tablet regimen without ribavirin for 12 weeks. The primary endpoint was sustained virological response, or continued undetectable HCV RNA at 12 weeks after finishing treatment (SVR12).

The overall SVR12 rate was 93.1% in an intention-to-treat analysis. Response rates were similar for HCV genotypes 1a, 1b and 4 (93.1%, 93.2% and 92.9%, respectively), and both people with genotype 6 were cured.

Five people – four with genotype 1a and one with genotype 4 – relapsed after completing treatment; four of these were on ART and one was HIV treatment-naïve.

In addition, two people were apparently reinfected after achieving sustained response (both had HCV genotype 1 at baseline and genotype 3 at week 12 of follow-up) and eight participants were lost to follow-up or discontinued treatment for reasons unrelated to virological failure.

In a modified analysis excluding the reinfections and people lost to follow-up or non-virologic failure, the overall SVR12 rate was 97.6%, and again was similar across genotypes.

There were no significant differences in response according to sex, age, race/ethnicity, high or low baseline HCV RNA or cirrhosis status. All 34 participants with cirrhosis were cured, as were 96.0% of patients without cirrhosis.

63% of participants had no NS5A resistance-associated variants (RAVs) at baseline and their SVR12 rate was 98%, while 37% had NS5A RAVs and their SVR12 rate was 94% – not a significant difference.

Sustained response rates also did not differ significantly according to NRTI backbone (97.5% with tenofovir and 95.7% with abacavir) or third antiretroviral (96.4% with raltegravir, 100% with dolutegravir and 94.6% with rilpivirine).

Treatment with grazoprevir/elbasvir was generally safe and well-tolerated, with no drug-related serious adverse events or discontinuations for this reason. The most common side effects were fatigue (13%), headache (12%) and nausea (9%).

Two participants experienced transient detectable HIV viral load during treatment but subsequently achieved undetectable HIV RNA without changing antiretrovirals. There was no notable change in CD4 cell count from baseline to treatment week 12.

"High rates of SVR were achieved in patients with HCV genotype 1, 4 and 6 and HIV coinfection receiving the all-oral, fixed-dose combination of [grazoprevir/elbasvir]," the researchers concluded. "With high SVR, low rates of adverse events, once-daily administration and suitability for use in patients also receiving antiretroviral therapy, [grazoprevir/elbasvir] represents another highly effective treatment option for patients with HCV/HIV coinfection."

Rockstroh noted that the SVR12 rate in C-EDGE Co-infection was similar to those seen in other C-EDGE trials of previously untreated and treatment-experienced HIV-negative people, and adverse events occurred with about the same frequency, adding to the evidence that people with HIV/HCV co-infection respond as well as HIV-negative people and no longer need to be considered a 'special population'.

After the presentation Jay Hoofnagle of the US National Institutes of Health said he would not necessarily assume that HCV reinfection had taken place, since simultaneous infection with multiple genotypes can occur and it might be that treatment eliminated genotype 1 while leaving genotype 3. Rockstroh, however, noted that cohort studies do suggest reinfection rates of around 25% among co-infected men who have sex with men, underlining the need for behavioural risk reduction.

**Reference:**

Rockstroh JK et al. High efficacy of grazoprevir/elbasvir (GZR/EBR) in HCV genotype 1, 4, and 6-infected patients with HIV coinfection: SVR24 data from the phase 3 C-EDGE coinfection study. AASLD Liver Meeting, abstract 210, 2015.

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

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## How to Talk About Consent Like a P\*rn Star

*In the wake of the James Deen rape allegations, we talked to industry insiders about how actors say yes on set.*

Madison Pauly, Mother Jones | 12.13

For the past several years, p\*rn star James Deen has been at the top of his industry. Known for his mainstream crossover appeal and popularity among women, Deen once told reporter Amanda Hess it was his "nonthreatening, everyday look" that gave him a leg up in the industry. (Indeed, one woman called him "the Ryan Gosling of p\*rn" on Nightline in 2012.) Though he doesn't identify himself this way, lady mags and news outlets alike labeled him a feminist.

Then, on November 28, p\*rn actor and producer Stoya tweeted that Deen, her former boyfriend, had raped her. The revelation rocked the relatively small adult-film community, and sparked a Bill Cosby-like cascade of allegations—some of which involved on-set incidents. At least 13 women have shared stories so far, ranging from excessive roughness to rape; Deen has since denied the claims.

American p\*rnography, an estimated \$10 billion industry, has years of knowledge to contribute to the cultural and legislative debate over how to define sexual consent: According to sexologist Carol Queen, p\*rn has been grappling with these questions for decades. This week, as p\*rn's practices have come under scrutiny following the allegations against Deen, we decided to ask adult actors, researchers, and advocates about how they handle consent. Here's what they had to say.

**How does the p\*rn industry talk about consent?** "There is a more developed everyday conversation about consent that goes on in the industry than you can find anywhere else," says Constance Penley, who teaches a class on the history of p\*rn at the University of California-Santa Barbara.

The conversation starts during contract negotiations, Penley says, when actors, often represented by agents, agree to the number and gender of partners, the kind of sexual acts, and how much they'll be paid for a shoot. The formality of the arrangement tends to increase with the size of the production company, ranging from verbal agreements on minor shoots to the three-page "limits" packet that performers fill out for Kink.com, a major producer of BDSM p\*rnography.

Still, consent in a contract is just paperwork. Sovereign Syre, who's been in the business for six years, says that before every shoot she's done, she also has talked to her co-stars about boundaries and preferences. The conversation continues throughout the scene. Even directors she's known for years, Syre says, will ask before tucking in the label on her underwear or rearranging her hair. If, during filming, things get too intense, actors on BDSM shoots use agreed-upon safe words. To stop, "red." To slow down, "mercy."

"Being on a p\*rn set, there should be far more room for you to convey those boundaries," says Cyd Nova, a p\*rn performer, producer, and the program director of the St. James Infirmary, a sex-worker-friendly clinic in San Francisco. Even if someone doesn't say no or use the safe word, professional adult actors are better equipped to notice when their partners are bothered or unenthusiastic, Nova says. "You're paid to understand and engage with people sexually."

**Doesn't money change things?** Of course. The mental, emotional, and physical calculus that most people use to determine their sexual boundaries shifts on set, where adult actors also have to consider their income. When they're under financial pressure, they might feel as if they can't afford to have a strict "no list." "When you've got \$1,000 on the line, there's a psychology at play that says, 'I'm willing to do it because I need the money,'" Syre says. Still, "that doesn't mean that they deserve to be abused."

It helps to be able to say no. Newcomers to the industry might not know they have that power, or they might be concerned about losing work, explains Conner Habib, vice president of the Adult Performers Advocacy Committee. (APAC is the closest thing p\*rn actors have to a union. Deen resigned from its board after the allegations began to surface, though it's still headed by his girlfriend). In part, it depends on the director: Most are receptive when performers ask to stop or change the scene, while Habib says others have asked him to reconsider his limits. A few are more insistent. "I've said no and had a director be like, 'You're not the director,' and I'll be like, 'Yeah, I don't care,'" Habib says.

Performers also may agree to try new sex acts on camera, signing up for more extreme shoots to make extra money, only to realize later that they felt traumatized by whatever they agreed to do, Syre says. "There's this larger dialogue going on about how can you consent to an act that is dynamic," she says. "There have been jobs I've gone on where I went home and I said, 'I don't want to do that again, or I don't like that person.' I don't think I've been traumatized by it. But I see that potential."

Habib says his consent has been violated on camera—it's just not anything he would label as rape. "I've definitely done scenes where I had a performer who just kept sticking his thumb up my ass," Habib says. He stopped the scene and told the man to quit it. "And then he did it again." Habib walked away for a few minutes. "When I came back, he said, 'I just totally forgot.'" They finished the scene, but Habib created what he calls an "inward boundary": If the man did it again, Habib would quit the shoot. "In my opinion, he's someone who shouldn't have worked in p\*rn because he wasn't able to listen."

**What are p\*rn actors' options for reporting rape?** For now, there's no protocol for reporting rape aside from going to authorities outside the industry. One obvious option is law enforcement—not an attractive choice for many people facing the stigma of sex work. Tori Lux says she decided not to tell the police that Deen raped her on set because of the common belief that women in p\*rn can't be assaulted. Likewise, Nicki Blue told the Daily Mail that she was afraid the police wouldn't believe her story about Deen: "When you're an adult actress, especially in BDSM, and you go to a cop and say, 'Oh I've been raped by this guy after doing a scene,' they are not going to take you seriously, like if you were a normal person."

Alternatively, actors could file reports with the California Occupational Safety and Health Administration, which investigates reports of workplace sexual assault (the industry is based in the San Fernando Valley, with 60 to 70 percent of US adult films shot in Los Angeles county). But several performers told us that battles over mandatory condom regulations have alienated workers from the agency, and Cal/OSHA has not received any sexual-assault complaints from the adult entertainment industry in the last 10 years.

Still, actors who consider reporting sexual assault to their producers and directors may be afraid of backlash, Habib says. A woman identifying herself by her initials, T.M., told LAist that she was afraid talking about Deen would hurt her career; Kora Peters says her agent at the time of her alleged rape told her she should be "honored" that Deen wanted her. The fear of blacklisting isn't far-fetched, according

to Nova: "If you say that you're assaulted at work, some producers may decide they don't want to work with you because they see you as a liability."

In the absence of mechanisms for reporting and accountability on set, performers try to warn each other about actors who push limits—the same kind of rumors some performers reported hearing about Deen. According to Syre, some circles of performers have successfully shut out men who became known for abusing their girlfriends. But for those who are new to the industry or lack connections, word of mouth is "not very foolproof," Nova says.

**How will the Deen allegations affect p\*rn moving forward?** It's difficult to say for sure, though at APAC's last meeting of performers, directors, and producers, attendees discussed designing a possible industry-wide reporting system. What is clear is that just because p\*rn has its own "best practices" doesn't mean that people follow them. Even with Kink.com's limits checklist, Ashley Fires, Nicki Blue, and Lily LaBeau all allege that Deen assaulted them under its supervision. There are rules, and then there are rule breakers—just as in any industry, Penley says. "This does not represent p\*rn," said Joanna Angel, a prominent alt-p\*rn director and actor who spoke about her past relationship with Deen to radio host Jason Ellis last week. "This represents a specific individual, and I do not want the public to blame p\*rn for anything."

Yet several industry-specific factors, from the lack of reporting options or the stigma that keeps women from talking to the authorities—or convinces them that speaking out would invite attacks on their community—work to keep many sexual-assault victims in p\*rn silent. "In the absence of people's legitimate issues being taken seriously and addressed," Queen says, "people tweet and write blogs and go to the court of public opinion."

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

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## **OPINION: No Reason to Exclude Transgender Medical Care**

Editorial Board, The New York Times | 12.9

A decade ago, when she was starting to transition genders, the artist known as Our Lady J steeled herself as she called endocrinologists, seeking one who would prescribe hormones. "I couldn't find a doctor," said the classical pianist and singer, who is currently a writer for the television series "Transparent." "I was treated like a freak."

Since then, the medical community in the United States has resoundingly concluded that transgender care — which includes hormone replacement therapy, counseling and surgical procedures — is medically necessary and should be covered by insurance.

Federal health officials say insurers and medical providers that discriminate against transgender individuals by denying transition-related care are violating the law. And a recent study by Johns Hopkins University found that providing transgender-related care is cost-effective in the long run because it generally reduces the likelihood of depression, anxiety and other conditions that take a toll on well-being and productivity. Moreover, the cost of this coverage for insurers would be negligible.

Yet transgender Americans continue to face significant barriers to affordable medical care because of exclusions in health insurance policies and a scarcity of specialized providers.

When Our Lady J learned this fall that the Writers Guild of America health plan, which provides an insurance plan for writers in Hollywood, does not cover transition-related care, she was distraught. It reminded her of a darker time in her life, when she was suicidal and struggled with substance abuse, largely as a result of being unable to afford the medical care she needed.

First, she wondered if the exclusion was an oversight, but then she learned that someone had challenged it this year and was turned down. “Having to battle for insurance and having to battle with doctors is overwhelming,” Our Lady J said. “Taking care of your health as a trans person can feel like a full-time job.”

Insurance coverage is only part of the problem. Even as more people gain coverage, many struggle to find doctors, especially surgeons, because medical providers have had little incentive to specialize in a field that the insurance industry has historically shunned.

For decades, transition-related care was a fringe medical specialty. There was no consensus among doctors about the wisdom and safety of helping people transform their bodies. Over time, as more people transitioned, researchers recognized that people who got treatment were more likely to lead healthy, productive lives.

The American Medical Association, the largest group of doctors in the country, published a landmark resolution in 2008 that said barriers to transition-related care needed to be eliminated, citing “an established body of medical research that demonstrates the effectiveness and medical necessity” of transition-related care. Every other prominent medical association in the country has echoed that assessment. But a corresponding shift in public policy has begun to take root only over the past couple of years.

In 2014, an Army veteran successfully appealed Medicare’s policy of refusing to pay for sex reassignment surgery. Federal health officials who reviewed her complaint concluded that such exclusions were “no longer reasonable,” in light of the growing body of medical research. The ruling changed Medicare policy and was a turning point in the fight for transgender equality, because private insurance providers and state officials often adopt Medicare coverage standards.

State officials in at least 12 states — including New York — and the District of Columbia have taken steps in recent years to bar insurance companies from excluding transgender care in policies.

The Department of Health and Human Services issued a proposed rule on the issue this summer, saying policies that categorically exclude gender transition care are discriminatory under the Affordable Care Act. Michael Silverman, the executive director of the Transgender Legal Defense and Education Fund, which advocates for transgender patients, said this could mark a transformational moment.

“But we will still see a period of time when entrenched attitudes and misconceptions continue to prevail,” he said. “Many people still don’t think of this as medically necessary care, so they reflexively deny claims because that’s what they’ve always done.”

Even in states that have prohibited insurance companies from denying transition care, discriminatory policies and practices are common. (The New York Times Company’s health insurance plans retain an exclusion for gender reassignment surgery; because they are self-funded, they are not required to

follow New York State policy.) The Writers Guild health fund in California, which is also self-funded, is not subject to the 2013 state policy that banned transgender care exclusions in insurance policies.

While a growing number of employers have phased out exclusions voluntarily, it often takes an individual willing to challenge the policy. Our Lady J has asked executives at the Writers Guild plan, which is expected to vote on proposed changes to its health plan on Wednesday, to do away with the exclusion. The guild should heed her call.

The collective toll these exclusions take on the transgender community, and American society, is sobering. Researchers have found that transgender people who are unable to transition medically are more likely to suffer from depression, more prone to self-destructive behavior and less likely to be employed.

“When you are living in a body you don’t identify with, it’s easy not to take care of that body,” Our Lady J said. “I am healthier because of what I have done with my transition. I am a more productive person. I am a better citizen.”

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

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## Scientific Papers/Conference Abstracts

### Prevalence Estimates of Complicated Syphilis

Dombrowski JC, Pederson R, Marra CM, et al. *Sex Transm Dis* 2015;42(12):702-704

**Abstract:**

We reviewed 68 cases of possible neurosyphilis among 573 syphilis cases in King County, WA, from 3rd January 2012 to 30th September 2013; 7.9% (95% confidence interval, 5.8%–10.5%) had vision or hearing changes, and 3.5% (95% confidence interval, 2.2%–5.4%) had both symptoms and objective confirmation of complicated syphilis with either abnormal cerebrospinal fluid or an abnormal ophthalmologic examination.

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

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### Effects of Brief Messaging About Undiagnosed Infections Detected through HIV Testing Among Black and Latino Men Who Have Sex With Men in the United States

Mansergh G, Miller P, Herbst J, et al. *Sex Transm Dis* 2015;42(12):691-693

**Abstract:**

We examined intent to get tested for HIV infection and use condoms among n = 604 uninfected black and Latino men who have sex with men after receiving brief information messaging that 1 in 10 minority men who have sex with men had HIV infection and did not know it. Information awareness, newness, believability, HIV testing cost willingness, and associated demographic variables were also assessed.

View the paper online: [Abstract](#)

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## Adaptation of the HIV Care Continuum as a Method for Evaluating Syphilis and Gonorrhea Disease Control Activities in Los Angeles County

Murphy RD, Wohl AR, Ma Y, et al. *Sex Transm Dis* 2015;42(12):686-690

### Background:

Treatment verification and contact elicitation are core approaches used to control the spread of sexually transmitted diseases (STDs). Methodology adapted from the HIV care continuum is presented as an evaluation and communication tool for STD control activities.

### Methods:

Sexually transmitted disease surveillance and program data for Los Angeles County in 2013 were used to construct a 2-part continuum to examine syphilis (all stages) and gonorrhea outcomes among index patients and elicited contacts. The Index Case Continuum (Part 1) assesses the proportion of patients who were treated, assigned for interview, interviewed, and provided name and locating information for at least 1 contact. The Elicited Contact Continuum (Part 2) assesses the proportion of contacts who were located, interviewed, and treated.

### Results:

Among 3668 patients with syphilis, 97% (n = 3556) were treated, 72% (n = 2633) were interviewed, and 25% (n = 920) provided name and locating information for at least 1 contact. The corresponding numbers for 12,541 gonorrhea cases were 95% (n = 11,936), 45% (n = 5633), and 16% (1944), respectively. Among the 1392 contacts elicited from syphilis cases, 53% (n = 735) were either interviewed or determined to not need an interview and 43% (n = 595) were treated. The corresponding numbers for the 2323 contacts elicited from gonorrhea cases were 53% (n = 1221) and 46% (n = 1075), respectively.

### Conclusions:

Adaptation of the HIV continuum is a useful tool for evaluating treatment verification and contact elicitation activities. In Los Angeles County, this approach revealed significant drop-offs in the proportion of index cases naming contacts and in the proportion of contacts who are interviewed and treated.

View the paper online: [Abstract](#)

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## Resources, Webinars, & Announcements

### CDC News: Two new initiatives to help Americans take control of HIV risk

Today, CDC debuts two **national HIV awareness and education initiatives that provide vital information to help people reduce their risk of infection:**

- *Doing It* is a **new national, bilingual HIV testing campaign** that uses humor to spark conversation and encourage people to get tested. Testing is essential to ending the HIV

epidemic—recent studies suggest that nearly one-third of new infections are transmitted by people who don't know they are living with HIV.

- CDC's **new comprehensive online [HIV Risk Reduction Tool](#)** is also debuting today, in beta form. The interactive tool provides customized information on the most current HIV prevention strategies, and houses a visual estimator that allows users to compare the risk of different sexual activities and explore how one or a combination of prevention methods changes the risk of infection.

With more options for prevention available than ever before, the new testing campaign and risk reduction tool provide Americans with the information they need to make the best choices for their health.

Please see our [press releases](#) for more information. Additional information detailing notable research presented at this year's conference will be posted on our [online newsroom](#) throughout the week as embargos lift.

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## Centers for Disease Control and Prevention (CDC) School Health Profiles - 2014 School Health Profiles Results Released

Today, CDC's Division of Adolescent and School Health (DASH) released the 2014 School Health Profiles (Profiles) results on the DASH Healthy Youth website at [www.cdc.gov/schoolhealthprofiles](http://www.cdc.gov/schoolhealthprofiles).

### The release includes:

- a comprehensive report that includes results from surveys conducted in:
  - 48 states
  - 19 large urban school districts
  - 2 territories
- a fact sheet describing Profiles and highlighting key 2014 results
- a PowerPoint presentation that presents state results, by quartiles, on a U.S. map
- all questionnaires and item rationales
- information on how to obtain Profiles datasets
- technical documentation for data analysis

Profiles Background: The School Health Profiles (Profiles) is a system of surveys assessing school health policies and practices in states, large urban school districts, and territories. Profiles surveys are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers.

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## FOA: Risk of Adolescence and Injury in HIV Susceptibility (RFA-AI-15-058)

Purpose: To understand how reproductive maturation or injury alters adolescent mucosal environments at HIV susceptible sites in order to provide the safest and most efficacious biomedical prevention strategies (e.g., topical microbicides and Pre-Exposure Prophylaxis (PrEP), etc.). For more information click [here](#).

For more information: [Click here](#)

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## Job/Internship Postings

### Director of Programs and Partnerships - NCSD

**Organization:** National Coalition of STD Directors (NCSD)

The National Coalition of STD Directors (NCSD) is hiring an exciting senior level position -- the Director of Programs and Partnerships.

The Director of Programs and Partnerships oversees a significant portfolio of work as Team Lead for the Technical Assistance and Health Equity Promotion (TAHEP) area of work. The TAHEP team responds to and empowers the work of NCSD's member health departments and other partners to prevent STDs and other adverse sexual health outcomes among disproportionately impacted populations to include adolescents, gay men and other men who have sex with men, and people of color. The Director is involved in day-to-day management of staff and projects undertaking multi-faceted initiatives in sexual health and STD prevention, and also is directly involved in delivering high quality trainings and presentations. The position is charged with developing and maintaining key partnerships to advance STD prevention and NCSD priorities and is expected to monitor budgets and assist the Executive Director in development to support TAHEP initiatives. This position is based in NCSD's Washington, D.C. office and reports directly to the Executive Director. The Director of Programs and Partnerships is a member of NCSD's Senior Team. The position has four direct reports.

NCSD is an equal-opportunity employer dedicated to a diverse workforce.

[The full job description can be found here.](#)

To apply, please send a cover letter, resume, short writing sample, and three professional references to [lmathias@ncsddc.org](mailto:lmathias@ncsddc.org). Position will be open until filled. No phone calls please.

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### Distance Learning Specialist – SF DPH

**Organization:** San Francisco Department of Public Health

**Location:** San Francisco, CA

**Salary:** \$32.36 - \$39.34/hour

**App. Deadline:** 12/18/15

The Department of Public Health is accepting applications for one (1) permanent exempt full-time position in Class 2589 Health Program Coordinator I within the Center for Learning and Innovation (CLI). CLI is a branch within the Population Health Division that is dedicated to fostering a culture of learning, trust, and innovation. It organizes several programs focused on 1) internal training and workforce development; 2) recruitment of the future public health workforce through meaningful internships; 3) catalyzing innovations in public health through human centered design principles; and 4) capacity building for external public health agencies and related stakeholders.

Under the direction of the CLI Manager for Capacity Building Initiatives, this position will play a key role in Project PrIDE, a project funded by the Centers for Disease Control and Prevention to increase the

uptake of HIV pre-exposure prophylaxis (PrEP) among men who have sex with men (MSM) of color and transgender persons at risk for infection.

The Distance Learning Specialist will work with the CBA Manager and others at CLI to develop and implement Distance Learning strategies. The Specialist's primary responsibilities are creating training materials including manuals, power point presentations, eLearning modules, and other teaching media. The Specialist will work closely with subject matter experts to convene learning communities in person and online using web-based videoconferencing software. The Specialist also will be responsible for maintaining a SharePoint repository of online learning resources (e.g., videos, toolkits, lectures) as well as CLI's Learning Management System to encourage online learning and exchange between staff from health departments and community partners. Finally, this position will collaborate with the overall grant team to assist with evaluation, reporting efforts, coordination of messages, and the highest standards for interactive learning.

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

**LOCATION:** 25 Van Ness Ave, San Francisco

**SHIFT:** 8:00am – 4:30pm Monday-Friday

This position performs the following essential duties:

- Engages internal and external staff and partners to identify knowledge, skill and abilities for successful delivery of PrEP.
- Leverages information gained through formal and informal needs assessments to recommend, design, develop and implement the appropriate learning solutions for the target audiences which may including online learning, instructor-led training, virtual training, instructional videos, audio/video scripts and role play exercises.
- Collaborates with subject matter experts to develop and review the training content and proactively identify additional experts who can address content gaps.
- Develops knowledge assessments and programs to measure student learning and application.
- Measures and assesses the effectiveness of in-person and on-line learning communities and training solutions to inform future program requirements and identify areas where additional learning and reinforcement are required.
- Actively reviews and evaluates the in-person and on-line training solutions library to determine when content needs to be updated, replaced, or retired.
- Builds and sustains participant-centered Learning Communities in cooperation with grant project staff and staff from CLI.
- Provides logistical support for the development and implementation of learning communities.
- Handles day-to-day operations, such as scheduling of events, for learning communities.
- Participates in assessment activities and collects and prepares data for internal, state and grant reports.

The Health Program Coordinator I (Distance Learning Specialist) also performs other related duties as assigned.

#### **Minimum Qualifications**

1. Possession of a baccalaureate degree from an accredited college or university; **AND**
2. One (1) year of verifiable administrative or management experience with primary responsibility for overseeing, monitoring, or coordinating a program providing health and/or human services.

**Substitution:** Additional experience as described above may substitute for the required degree on a year-for-year basis (up to a maximum of 4 years). Thirty (30) semester units or forty-five (45) quarter units equal one year. One (1) year of experience is equivalent to 2,000 hours.

**DESIRED QUALIFICATIONS:**

- Possession of a baccalaureate degree with major in health education or a related communications field.
- 3 - 4 years of health education curriculum development experience or instructional design (a Master's degree in a health education-related field can substitute for up to 2 years of experience).
- Experience managing, developing, and delivering health education content, including working with subject matter experts.
- Experience in the area of high impact HIV prevention, including PrEP.
- Proficiency creating eLearning courses using authoring software such as Articulate.
- Excellent data visualization skills and creation of compelling infographics.
- Proficiency with Microsoft Word, PowerPoint, SharePoint, webinar software (e.g., GoToMeeting), and videoconferencing software (e.g., Zoom).
- Experience working on HIV and/or public health issues with diverse racial/ethnic communities, particularly communities of color as well as gay/lesbian/bisexual/transgender communities.
- Experience liaising with contractors and vendors and managing budgets.
- Experience with grant preparation and reporting, including NIH and CDC grants.

**How To Apply**

Applications for City and County of San Francisco jobs are being accepted through an online process. Visit [www.jobaps.com/sf](http://www.jobaps.com/sf) to register an account (if you have not already done so) and begin the application process.

- Select the desired job announcement
- Select "Apply" and read and acknowledge the information
- Select either "I am a New User" if you have not previously registered, or "I have Registered Previously"
- Follow instructions on the screen

Computers are available for the public (from 8:00am to 5:00pm Monday through Friday) to file online applications in the lobby of the Department of Human resources at 1 South Van Ness Avenue, 4<sup>th</sup> Floor, San Francisco.

You can also watch this video for further assistance with our online application system:

<http://www.youtube.com/watch?v=4-kUFHXhBjQ&feature=youtube>

Applicants may be contacted by email about this announcement and, therefore, it is their responsibility to ensure that their registered email address is accurate and kept up-to-date. Also, applicants must ensure that email from CCSF is not blocked on their computer by a spam filter. To prevent blocking, applicants should set up their email to accept CCSF mail from the following addresses (@sfgov.org, @sfdpw.org, @sfport.com, @flysfo.com, @sfwater.org, @sfdph.org, @asianart.org, @sfmta.com, @sfpl.org).

Applicants will receive a confirmation email that their online application has been received in response to every announcement for which they file. Applicants should retain this confirmation email for their records. Failure to receive this email means that the online application was not submitted or received. All work experience, education, training and other information substantiating how you meet the minimum qualifications, if requested, must be included on your application by the filing deadline.

Information submitted after the filing deadline will not be considered in determining whether you meet the minimum qualifications.

Applications completed improperly may be cause for ineligibility, disqualification or may lead to lower scores.

Resumes may be attached to the application, however resumes will not be accepted in lieu of a complete City and County of San Francisco application.

If you have any questions regarding the application process, please contact the exam analyst, Katelynn Luong, at (415) 554-2920 or email: [Katelynn.Luong@sfdph.org](mailto:Katelynn.Luong@sfdph.org).

For questions regarding the vacancies, please contact the hiring manager, Gary Najarian, at (415) 437-6226 or email: [Gary.Najarian@sfdph.org](mailto:Gary.Najarian@sfdph.org).

**Verification (proof) of Education:**

Applicants may be required to provide a copy of a diploma or official transcript to verify qualifying education at any time in the application, examination and/or departmental selection process, to show that minimum qualifications have been met.

Applicants who have obtained education from a foreign college or university must provide a Foreign Transcript Evaluation letter from a National Association of Credentials Evaluation Service (NACES) approved agency. A list of approved agencies can be found at: <http://www.naces.org>

**Verification (proof) of Experience:**

Applicants may be required to submit verification of qualifying education and experience at any point in the application, examination and/or departmental selection process. If verification is required, failure to provide it may result in disqualification from the selection process.

Verification of qualifying experience must be signed by the employer's authorized representative on the employer's letterhead, and specify the name of the applicant, dates of employment, job title(s), dates of service and duties performed. City and County of San Francisco employees will receive credit for the duties of the class to which the employee was appointed. City and County of San Francisco employees do not need to submit verification of their City employment, but must submit verification of outside experience. City employment will be verified by the employee's record. City and County of San Francisco employees will not receive credit for experience obtained outside of their classification unless recorded in accordance with the provisions of the Civil Service Rule 110.9.1. For more information, please visit: <http://www.sfdhr.org/index.aspx?page=20#verification>.

**NOTE:** Falsifying one's education, training, or work experience or attempted deception on the application may result in disqualification for this and future job opportunities with the City and County of San Francisco.

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

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