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California Stories

Prescription-Free Birth Control Coming To California

Kenny Goldberg, KPBS | 2.15

Coming soon: prescription-free birth control.

This spring, a doctor's prescription will no longer be needed for women to buy birth control in California.

A law authorizing pharmacists to dispense hormonal contraceptives was passed in 2013. It's expected to be enacted this April.

California will become the third state to allow pharmacists to furnish birth control without a prescription. They'll be able to dispense hormonal patches, pills and vaginal rings.

Women will have to answer a brief screening questionnaire before they get birth control. It's designed to reveal any health concerns that might prompt a referral to a doctor.

There is no age requirement for women to buy birth control in California.

Supporters say the law will increase access to contraceptives and reduce unwanted pregnancies.

But some fear it could have unintended consequences. There's concern that not requiring a doctor's visit could mean fewer women will get screened for sexually transmitted diseases.

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

California Rejects Measure To Require Condoms In Porn

Devon McReynolds, LAist | 2.19

A measure that would have required condoms to be used in all porn shot in California failed to pass on Thursday.

In a hearing in Oakland that lasted five hours, according to NBC L.A., dozens of porn actors, directors and producers testified in front of the California Division of Occupational Safety and Health's (Cal/OSHA) Standards Board, saying that such a measure would hurt the industry, and put their jobs in jeopardy.

This video, taken from the end of the hearing by Mike Stabile of the Free Speech Coalition, shows the audience (allegedly made up of mainly porn actors) positively reacting to the decision:

[Follow link below for video]

"I ask you not to approve this policy that will endanger me and my colleagues," porn actress Maxine Holloway said during the hearing.

Another speaker, who identified herself as a sex worker, echoed the sentiments of others who got up to speak, by saying that much of their audience just isn't into porn that shows actors with condoms. "Like it or not, there's a very real market demand for condomless sex," she said.

One of the arguments against using condoms in porn is that the measure would force the industry to operate "underground," which would make it inherently less safer than it is now. Many suggested that the requirement to wear condoms would in a sense nullify the porn industry's own requirement that actors be tested for STDs every 14 days.

According to the L.A. Times, one porn actress named SiouxsieQ made those points, saying, "I know you guys work really hard and have our best interests at stake, but we need you to work with us to find a solution... When you criminalize sex work in any way, you make it more dangerous."

Only three members of the Cal/OSHA board voted in favor of the measure; four votes were required for it to pass. The 21-page proposal called for controls "such as condoms" to be used by actors in porn to reduce the risk of transmitting HIV and other sexually transmitted diseases. The proposal also would require producers to pay for their performers' medical visits, treatments and other health-care costs.

Spokeswoman Julia Bernstein said that now the board would be working on alternatives to make the workplace safer.

Those opposed to the measure applied a slippery-slope argument, saying that the enforcement of condoms would lead to the requirement of dental dams and safety goggles—decidedly un-sexy protective equipment.

But Michael Weinstein of the AIDS Healthcare Foundation (which has lobbied Cal/OSHA for years) said this was "pure fantasy."

Weinstein expressed his disappointment in a statement, saying the measure "would have resulted in improved worker safety for adult film workers in California."

Weinstein also noted that condoms are already required for films made in L.A. County, thanks to the ordinance Measure B, which was adopted in 2012.

"To be clear, condom use in adult film production in California—one of only two states in which adult film production is legal—already is required under California's Bloodborne Pathogens standard," Weinstein continued. "We are announcing today that we will immediately file a new petition with Cal/OSHA on this important health measure."

"People have suffered serious consequences due to lack of regulation in this industry," said Weinstein. The bi-weekly STD tests are apparently not enough: former porn actor, Derrick Burts claims he was infected with HIV while shooting porn, despite complying with the testing protocol.

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

National Stories

PrEP Fails in Gay Man Adhering to Daily Truvada, He Contracts Drug-Resistant HIV

Benjamin Ryan, POZ | 2.25

Researchers have for the first time documented a case of an individual contracting HIV, a multi-drug resistant strain, while apparently adhering well to the daily regimen of Truvada (tenofovir/emtricitabine)

as pre-exposure prophylaxis (PrEP). The scientists concluded that it is indeed possible for individuals who are adherent to PrEP to contract HIV when they are exposed to a virus that is resistant to both drugs included in Truvada.

While this case is concerning, experts in the PrEP field believe that such failures of PrEP will likely remain rare.

David Knox, MD, an HIV specialist at the Maple Leaf Medical Clinic and the lead author of the case study, presented findings at the 2016 Conference on Retroviruses and Opportunistic Infections (CROI) in Boston.

Evidence suggests that the individual in question, a 43-year-old Canadian man who has sex with men, adhered well to PrEP over the long-term. Nevertheless, after 24 months on Truvada he tested positive for HIV. Initial tests indicated that he was acutely (very recently) infected: He tested positive for the p24 antigen, which appears within about three weeks of HIV infection and disappears a few weeks afterward; and at that time he tested negative for HIV antibodies, which typically appear two to eight weeks after infection.

Researchers estimate that men who have sex with men (MSM) who take Truvada at least four times a week are more than 99 percent protected against HIV. (CDC guidelines advise taking Truvada daily for maximum protection, but the drug apparently has a good amount of dosing “forgiveness.”) Real-world use of Truvada as HIV prevention has suggested it is indeed highly effective. For example, none of the more than 1,400 generally high-risk individuals taking PrEP through the Kaiser Permanente San Francisco PrEP program have contracted HIV to date, despite their very high rate of other sexually transmitted infections, including two cases of hepatitis C virus (HCV) .

All of PrEP’s power to curb HIV notwithstanding, this new case study underlines the fact that in science there is, unfortunately, no 100 percent guarantee.

“After 32 years of experience with HIV research, I have learned never to say ‘never’,” said Robert M. Grant, MD, MPH, a professor at the University of California, San Francisco, who was the head of the iPrEx trial that first proved PrEP’s effectiveness among MSM and transgender women in 2010. “Yet I also think that gay men benefit from feeling safer during sex, and I am grateful that PrEP affords that feeling.”

Pharmacy records indicated that the man in the case study had consistently filled his Truvada prescription on schedule. Dried blood-spot testing on a sample taken 16 days after he tested positive for HIV indicated that he had adhered well to Truvada during the previous one to two months, a period that overlapped with the estimated time when he contracted the virus.

“This person claims he was taking PrEP every day and I believe him,” said Grant.

Tests for antiretroviral (ARV) resistance that were conducted on a sample taken a week after the man tested positive for HIV indicated that his virus was clade B HIV-1 and CCR5 tropic (meaning it attached to the CCR5 coreceptor on the surface of CD4 cells, as opposed to the CXCR4 coreceptor). Tests also indicated that his drug resistance had been transmitted from another person, rather than acquired post-transmission. A genetic analysis of his virus conducted on a sample taken a week after he tested positive suggested that he contracted the virus from a single individual.

The man's virus was resistant to multiple drugs. It had numerous nucleoside reverse transcriptase inhibitor (NRTI) resistance mutations, including those known as 41L, 67G, 69D, 70R, 184V and 215E, which in the resistance tests reduced the response to Ziagen (abacavir) by 1.9 fold, raised the resistance to EpiVir (lamivudine) by 61 fold, raised the resistance to Emtriva (emtricitabine, which is one of the two drugs in Truvada) by 38 fold, and reduced the response to Viread (tenofovir, the other drug in Truvada) by 1.3 fold. The virus also had the non-nucleoside reverse transcriptase (NNRTI) resistance mutation 181C, raising the resistance to Viramune (nevirapine) 43 fold. Lastly, the virus had mutations conferring reduced response to all integrase strand-transfer inhibitors (INSTIs), including 51Y and 92Q, which reduced the response to Isentress (raltegravir) 2.7 fold, increased resistance to Vitekta (elvitegravir) by greater than 100 fold, and reduced the response to Tivicay (dolutegravir) 9.6 fold.

Despite all these resistance mutations, the man in the case study is currently on successful HIV treatment, with a fully suppressed viral load. He is taking Tivicay (dolutegravir), PrezcoBix (darunavir/cobicistat), and Edurant (rilpivirine).

Recent research suggested that, among HIV-positive individuals failing treatment regimens, resistance to tenofovir, which is the most commonly prescribed ARV in the world, is increasing. Perhaps as much as 1 percent of all individuals who contract HIV today inherit virus that has mutations conferring resistance to tenofovir. Resistance to emtricitabine is more common, likely because only a single resistance mutation is required to confer resistance to that drug, while for tenofovir more than one mutation is usually required.

What is more rare is a virus that is highly resistant to both tenofovir and emtricitabine, as in this new case report. Indeed, according to Grant, among more than 9,200 participants in the clinical trials of PrEP, such a virus that was highly resistant to both components of Truvada was never seen.

According to Richard Harrigan, PhD, director of the lab program at the British Columbia Center for Excellence in HIV/AIDS in Vancouver, Canada, who was one of the researchers on this case study, "I think we would assume that the efficacy of PrEP would be lower if there is exposure to virus which is resistant to either drug, and lowered further if there is exposure to virus resistant to both drugs."

There have been two documented cases of men contracting HIV while taking tenofovir alone for hepatitis B virus (HBV) treatment. One of these individuals did not have a tenofovir-resistant strain of the virus, while researchers could not determine if the other person had such resistance. These cases apparently stress the importance of using two drugs for PrEP rather than one, even in the absence of resistant virus—at least when using the components of Truvada. (Another study presented at CROI compared the single drug Selzentry (maraviroc) to Truvada as PrEP.)

Reflecting on the new case study, Harrigan said, "I certainly don't think that this is a situation which calls for panic. It is an example that demonstrates that PrEP can sometimes be ineffective in the face of drug resistant virus, in the same way that treatment itself can sometimes be ineffective in the face of drug resistant virus."

Harrigan added, "This case demonstrates that while PrEP is beneficial, we can't rely on it to be an infallible magic bullet."

To read the conference abstract, click [here](#).

Editor's note: There has been concern among some readers about the statement in this article asserting that researchers estimate that taking four or more tablets of Truvada per week reduces the risk of HIV among MSM by more than 99 percent. This figure comes from the 2014 iPrEX open-label extension study, which used mathematical modeling to reach this estimate. No participant in a PrEP clinical trial has contracted HIV while apparently taking Truvada at least four days per week.

Older estimates of PrEP's effectiveness come from two papers. The 2010 iPrEX study estimated that among those who had any detectable drug in their systems, Truvada reduced the risk of infection by 92 percent among MSM. A 2012 analysis of that paper used mathematical modeling to estimate that taking seven tablets of Truvada per week reduced the risk of HIV by 99 percent.

Today, many research papers that examine adherence to PrEP use four-plus tablets per week as the threshold for maximum adherence; they do not even differentiate between taking seven tablets per week and taking four to six tablets per week.

For a more detailed description of these figures, please refer to the end of [this article](#).

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

CDC: Half of Gay Black Men Will Get HIV

For the first time ever, federal officials estimated how likely blacks and Hispanics are likely to be diagnosed with the virus that causes AIDS.

Samantha Allen, The Daily Beast | 2.23

Half of gay and bisexual black men and a quarter of gay and bisexual Hispanic men will be diagnosed with HIV in their lifetimes, the Centers for Disease Control announced in a first-of-its-kind study on Tuesday.

While the lifetime risk of a positive HIV diagnosis has fallen from 1 in 78 Americans overall in 2005 to 1 in 99 today, the decline has not been distributed equally among the U.S. population. For the foreseeable future, the CDC estimates that gay, bisexual, black and Hispanic people will continue to bear the brunt of the HIV epidemic. The new study is the first time that the CDC has estimated lifetime HIV risk based on race.

Overall, the CDC projected that one in 64 men and one in 227 women in the United States will be diagnosed with HIV at current rates. For black and Hispanic people, however, that risk increases dramatically.

Regardless of sexual orientation, one in 20 black men and one in 48 black women will be diagnosed with the virus that causes AIDS in their lifetimes, according to the CDC. For Hispanic men and women, the risks are one in 48 and one in 227, respectively.

White people have the lowest chance of an HIV diagnosis, with an overall lifetime risk of less than one percent. Gay and bisexual white men still have a lifetime risk of one in 11, though.

The CDC's projections are based on data about HIV diagnoses and death rates collected from 2009 to 2013, and they assume that rates of new diagnoses remain constant. If that's the case, one in six men who have sex with other men will be diagnosed with HIV in their lifetimes.

"These estimates are a sobering reminder that gay and bisexual men face an unacceptably high risk for HIV—and of the urgent need for action," said Dr. Eugene McCray, director of the CDC's Division of HIV/AIDS Prevention. "If we work to ensure that every American has access to the prevention tools we know work, we can avoid the outcomes projected in this study."

For Hispanic people living in the United States, the CDC has already outlined an array of factors behind the alarming rate of new infections: a high prevalence of HIV, poverty and lack of health insurance coverage, "machismo" that can encourage men to engage in risky sexual behavior as a show of strength, and reluctance to access prevention services for fear of revealing one's immigration status.

In South Florida, for example, an already high prevalence of HIV has combined with low awareness of the virus and social stigma to produce the highest rate of new infections in the U.S., driven largely by new infections among young Hispanic men.

For black people, CDC resources show, prevention challenges are similar: poverty, stigma, barriers to health care access, and too few people knowing their status. Risk in black communities is especially high, the CDC notes, because "African Americans tend to have sex with partners of the same race/ethnicity mean[ing] that [they] face a greater risk of HIV infection with each new sexual encounter."

According to the CDC's new projections, all of the states with the highest lifetime risk for HIV are in the South, with the exceptions of New York, New Jersey, Delaware, and the District of Columbia. All of these states and the South tend to have large black and Hispanic populations, higher rates of poverty, and less health-insurance coverage.

The CDC estimates that HIV risk is highest in Maryland, Georgia, Louisiana, and Florida, with about 2 percent of these states' populations believed to test HIV positive eventually.

No single area may be worst-hit than Washington, D.C., which is nearly 50 percent black and 10 percent Latino. According to the CDC's projections, a staggering one in 13 D.C. residents will be diagnosed with HIV in their lifetimes.

But the CDC doesn't want its projections to be interpreted as a death sentence.

"As alarming as these lifetime risk estimates are, they are not a foregone conclusion. They are a call to action," said Dr. Jonathan Mermin, director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention.

If the U.S. can reduce new infections, those lifetime risk numbers will go down, too. The CDC's current prevention approach emphasizes HIV testing, condom use, treatment for those who have already been diagnosed, and pre-exposure prophylaxis (PrEP), a daily medication that has been shown to reduce risk by more than 90 percent when used correctly.

“The prevention and care strategies we have at our disposal today provide a promising outlook for future reductions of HIV infections and disparities in the U.S.,” said Dr. Mermin, “but hundreds of thousands of people will be diagnosed in their lifetime if we don’t scale up efforts now.”

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

Vaginal rings containing antiretroviral moderately effective in preventing HIV – but not in the youngest women

Results pose dilemma for product development

Gus Cairns, aidsmap | 2.22

The results of two studies announced today at the annual Conference on Retroviruses and Opportunistic Infections (CROI 2016) in Boston, USA, show that vaginal rings impregnated with an anti-HIV drug are effective at cutting the HIV infection rate in women. However, the overall effectiveness seen was only moderate, preventing less than a third of infections – and the primary reason for this was that the rings had no effect at all in the youngest trial participants, aged 18-21 – who also had the highest rates of HIV infection. The rings were more effective in older women with almost two-thirds of infections prevented in women over 25 in ASPIRE.

Researchers are still teasing out why the vaginal rings did not work for the youngest women. Some of the low effectiveness seen was undoubtedly due to poor adherence but drug level tests did not suggest adherence rates so low as to produce zero effectiveness. The results could be caused by a combination of intrinsic efficacy of less than 100% in the rings, intermittent use among participants, and greater vulnerability to HIV infection among young women.

Whether these are the reasons, or others for the relatively low levels of adherence and lack of effect seen in young women, remains to be seen. The same is true of whether these results will be enough for the ring to be licensed as a protection method.

The two studies

The two studies, the ASPIRE study and the Ring study, jointly enrolled 4588 HIV-negative women aged 18-45 in 22 sites in South Africa, Uganda, Malawi and Zimbabwe. ASPIRE enrolled 2629 women at 15 sites and the Ring study 1959 at seven sites.

The findings from ASPIRE were published in the New England Journal of Medicine today. Only interim results from the Ring study were presented at a press conference today. Both studies will present fuller findings at CROI on Wednesday

Both studies had the same design: the women were given a silicone polymer ring designed to be worn inside the vagina for one month and then changed for another one. Half the rings were impregnated with 25 milligrams (mg) of a non-nucleoside reverse transcriptase inhibitor (NNRTI) anti-HIV drug called dapivirine, which was never licensed as an oral drug due to poor systemic absorption. Previous studies indicated that these rings should be able to deliver enough drug throughout a month to prevent HIV infection.

The vaginal-ring technology is not new, it is already used to deliver hormonal contraceptives, though in that case the rings are not worn during the period of menstruation.

The ASPIRE study, run primarily by the Microbicides Trials Network (MTN), is fully complete; the Ring study, run primarily by the International Partnership for Microbicides (IPM), was still proceeding when the ASPIRE results became known and all women on the placebo arm were offered a ring containing active drug.

Adherence has been shown to be the primary influence on whether oral pre-exposure prophylaxis (PrEP) and microbicides work, so the women in both trials were given regular drug-level tests. Dapivirine is to some extent systemically absorbed, and a dapivirine level in the blood of more than 95 picograms per millilitre (pg/ml) indicated that the ring had been in place for more than eight hours before the drug level measurement. However, this measure was only able to establish that the women wore the ring on the day of the blood test. So a year into ASPIRE, researchers also started measuring drug levels in returned rings: if there was less than 23.5mg of drug left in the ring after a month's use – i.e. if at least 1.5mg had leached out – then the women were deemed to be adherent.

ASPIRE study – details

In ASPIRE, at enrolment, the average age of participants was 26. Forty-one per cent were married; 85% had had at least some secondary education; virtually all had one primary sexual partner but 17% had had more than one partner in the previous three months. Fifty-seven per cent said they had used a condom last time they had sex. Six per cent had engaged in transactional sex in the last three months and 2% in anal sex. Nearly two-thirds (64%) said their partners knew they were in the study.

More details of ASPIRE participants are given in this aidsmap.com report from last year.

Nearly four in every hundred participants became pregnant per year (annual pregnancy incidence 3.95%). Women were suspended from the study while pregnant or breastfeeding.

Retention was good, with more than 85% of women remaining in the study and on average staying in the study for 1.6 years, with 39% staying in the study for more than two years.

ASPIRE: effectiveness and adherence

There were 168 HIV infections among ASPIRE participants: 71 using dapivirine rings and 97 using placebo rings. This translates to an effectiveness of 27%, i.e. slightly more than one in four HIV infections that would otherwise have happened was prevented.

This is disappointingly low. But there was a very strong interaction between effectiveness and age. There was zero effectiveness in women aged 18-21. In women aged over 21, effectiveness was 56% – i.e. more than half of all infections prevented – and in women over 25 it was 61%.

ASPIRE also had a specific difficulty in that it became clear early on that two out of the 15 sites were having problems with recruiting and monitoring participants. These two sites and their participants were excluded from the rest of the study apart from follow-up HIV testing. When these two sites were excluded, effectiveness in the other 13 was 37%.

In women whose partners knew they were in the study, effectiveness was 44%, and in those whose partners did not know, it was 29% although this was not a statistically significant difference.

The drug level tests found dapivirine in 82% of blood samples, though as noted above all this meant was that the participant had used the ring that day. However in 84% of returned rings, drug levels indicated consistent if not constant use through the month. In nine per cent of samples, test results were discordant, with high levels of dapivirine in blood, but very little drug having left the ring – this might indicate ‘white coat dosing’ or women only inserting the ring on the day they went to the clinic.

Interestingly, there was no indication of decrease in adherence as time went on – rather the opposite. Adherence seemed to improve after the first month and also after the first year, and the difference in infection rates between dapivirine and placebo arms only became apparent in most age groups after a year. This seems to be a technology that women have to get used to.

The Ring study: preliminary effectiveness and incidence results

Preliminary efficacy results were also announced from the Ring study at the conference. The overall efficacy seen in the Ring study was 31% (compared with 27% in ASPIRE). The same relationship with age was seen, though not as strongly; efficacy in women over 21 was 37%, compared with 56% in ASPIRE.

The Ring researchers also gave a figure for the HIV incidence rates among women in the placebo arms of both studies. It was 8.2% a year in women under 21, 7.3% in women aged 21-25 and 4.3% in women aged over 25, again showing that it is young women under 21 who are in greatest need of a prevention method that can truly protect them.

Next steps and comments

The Ring researchers said that despite the fact that only moderate effectiveness was demonstrated, plans were underway for a follow-up open-label study for Ring participants, and possibly ASPIRE participants too, starting in April 2016. The rationale of this is that in some PrEP studies, adherence and effectiveness have been higher in participants when they know they are all using the active drug. If results are promising, then there would be an application for a product licence from early 2017.

Dr Zeda Rosenberg, founding Chief Executive Officer of IPM, said: “IPM will seek regulatory approval for the monthly dapivirine ring and work with partners to determine its role in strengthening HIV prevention efforts. We are also hopeful we can learn more about how to help women who want to use the ring do so consistently. A follow-on study would help answer key questions about how women could use the ring when they are aware it can safely offer protection.”

Dr Jared Baeten, who co-led the ASPIRE study, said: “Women – especially in sub-Saharan Africa – need multiple options for HIV prevention. The ASPIRE study was an important step towards determining whether the dapivirine ring could become one such option.”

Dr Anthony Fauci, Director of the National Institute of Allergies and Infectious Diseases, primary funder of the ASPIRE study, said: “Women need a discreet, long-acting form of HIV prevention that they control and want to use. This ring confers partial protection, [but]... further research is needed to understand the age-related disparities in the observed level of protection.”

Questions to be answered

Why were the results of these studies relatively disappointing? Firstly, the ring technology probably does not have the same intrinsic efficacy as oral PrEP; one researcher told [aidsmap.com](#) that 100% adherence probably implied an efficacy of about 70%.

Secondly, however, it has become clear from qualitative studies that what women might like in a vaginal ring was not necessarily on offer from these particular ones. A recent study investigated the characteristics thought more and less desirable by women who used contraceptive rings and found women would prefer a ring that was a little more pliable and thinner than the HIV prevention one.

In addition, women preferred to be able to take the rings out and clean them, did not like wearing them during menstruation, and some preferred to take them out even during sex (which might not inevitably mean loss of efficacy as long as they were immediately replaced). This was also the case in a previous acceptability trial of another HIV ring. While women were reassured about safety, some participants could not rid themselves of the feeling that retaining the ring felt 'dirty', especially during their menstrual period, and they remained aware of wearing it, rather than forgetting it was there except when it needed to be changed.

One reason Zeda Rosenberg thinks this is unlikely to apply is any biological difference between the youngest women and others. "There's not a lot of difference between 19 and 21 year olds," she told [aidsmap.com](#).

Whether any of these are the reasons or others (such as fear of discovery, or inconvenience) for the relatively low levels of adherence and lack of effect seen in young women remains to be seen.

The same is true of whether these results or the ones from an open-label trial will be enough for the ring to be licensed as a protection method in addition to oral PrEP, which South Africa has already licensed.

References:

Baeten JM et al. [Use of a vaginal ring containing dapivirine for HIV-1 prevention in women](#). NEJM, early online publication. DOI: 10.1056/NEJMoa1506110. 22 February 2016.

Baeten JM et al. *A phase III trial of the dapivirine vaginal ring for HIV-1 prevention in women*. CROI 2016 conference, Boston. Abstract 109LB.

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

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

Nel A et al. *Safety and efficacy of dapivirine vaginal ring for HIV-1 prevention in African women*. CROI 2016 conference, Boston. Abstract 110LB.

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

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

[You can view a webcast of the press conference including information on these studies on the conference website.](#)

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

NIH-Funded Study Finds Critical Population Adheres to PrEP with Coordinated Care

Press Release, NIAID | 2.24

WHAT:

New findings suggest that black men who have sex with men (BMSM) with access to a novel coordinated care program can adhere to pre-exposure prophylaxis (PrEP), a medication regimen that helps prevent HIV infection in uninfected individuals. Researchers reported their results today at a press conference at the Conference on Retroviruses and Opportunistic Infections (CROI) in Boston.

The study, known as HPTN 073, was conducted by the HIV Prevention Trials Network (HPTN) and funded by the National Institute of Allergy and Infectious Diseases (NIAID) and the National Institute on Drug Abuse, parts of the National Institutes of Health. Research sites in the District of Columbia; Los Angeles; and Chapel Hill, North Carolina, recruited 226 BMSM to participate.

After a screening to confirm an HIV-negative status, clinicians offered BMSM participation in a program called client-centered care coordination, or C4, as well as PrEP to self-administer daily in pill form. Nearly 80 percent of the trial participants agreed to take PrEP at the onset of the study. At its midpoint, approximately 70 percent of participants who first accepted PrEP had protective levels of the drug in their plasma. At the close of the 52-week study, 67 percent of participants reported that they were continuing to adhere to the daily regimen, although plasma data are not yet available to confirm these reports.

This research builds upon a 2012 study known as HPTN 061 that found a disproportionately high incidence of HIV among gay and bisexual black men and supported the need for prevention programs specifically tailored to this at-risk population. That study found BMSM are likely to face psychological and social problems and encounter barriers to accessing care. The C4 intervention was designed to address some of these issues to increase the likelihood that participants would adhere to PrEP. In voluntary C4 sessions, a team of health care professionals provided counseling, care and referrals for client-identified problems, including substance use, homelessness, mental health and medical issues and intimate partner violence.

Researchers intend to further analyze data to determine reasons BMSM gave for refusing or accepting PrEP, as well as correlations between plasma drug levels and number of C4 sessions attended.

EVENT:

These findings were presented today at the 23rd Conference on Retroviruses and Opportunistic Infections at the John B. Hynes Veterans Memorial Convention Center in Boston.

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

HPV rates fallen sharply in young women since vaccine introduced

Catherine Paddock, Medical News Today | 2.24

Since 2006 in the US, routine human papillomavirus vaccination has been recommended for girls aged 11-12 years and also for other young women up to 26 years of age who were not immunized earlier.

Now, new research finds that in the 6 years following human papillomavirus (HPV) vaccine introduction, rates of infection of the four strains targeted by the vaccine have plummeted in teen girls, and they have also fallen significantly in other young women.

The study - from the Centers for Disease Control and Prevention (CDC) - is published in the journal *Pediatrics*.

The authors say the findings extend previous results about the impact of the HPV vaccine in the US and provide the first national evidence of its effect on women in their 20s.

The aim of the HPV vaccination campaign is to protect against cancer. More than 40 types of HPV can infect the genital areas of males and females. These types can also infect the mouth and throat. The virus is transmitted from one person to another during sexual activity.

HPV can cause cervical, vaginal and vulvar cancers in women and cancer of the penis in men. It can also cause anal cancer, cancer of the back of the throat (oropharynx), and genital warts in both men and women.

HPV is very common: the CDC estimate that currently in the US, there are around 80 million people infected with HPV, with 14 million new infections - including among teenagers - occurring every year.

Most people infected with HPV do not know they have it.

The HPV vaccine is recommended for pre-teen males and females aged 11-12 so that they are protected before there is a chance of exposure. The vaccine also produces a more robust immune response if received at this age.

Another reason to give the vaccine to pre-teens is because later on, they are less likely to get regular health checks, thus providing fewer opportunities to receive the vaccine routinely.

HPV vaccine is given in three shots - with the second shot 1 or 2 months after the first, and the third 6 months after the first.

64% reduction in teen girls

For the study, researchers looked for genetic evidence of HPV in cervical/vaginal samples that were self-collected by females aged 14-34 years who took part in National Health and Nutrition Examination Surveys.

They compared data from 2,587 females whose samples were collected before the vaccine was introduced (2003-2006) with those of 2,061 females whose samples were collected afterward (2009-2012).

The results showed that the percentage of females who reported receiving at least one dose of HPV vaccine following its introduction ranged from 3.3% of those aged 30-34 years to 51% of those aged 14-19 years.

They also show there was a 64% reduction in prevalence of the four strains of HPV included in the vaccine in teen girls aged 14-19 years and a 34% decrease among young women aged 20-24 years.

The HPV vaccine immunizes against HPV types 6, 11, 16 and 18, the strains thought to cause the most cancer cases. The researchers note that:

"There were no statistically significant changes in other HPV type categories that indicate cross-protection."

In October 2015, Medical News Today learned that the reason some parents are not having their children vaccinated against HPV may be largely down to discouragement from doctors.

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

Federal budget sustains HIV funding, requests more for PrEP

Liz Highleyman, Bay Area Reporter | 2.18

Funding for domestic HIV services saw a modest increase in President Barack Obama's proposed budget for fiscal year 2017 – including a \$20 million allocation for a new PrEP pilot program – but advocates say it does not provide enough for HIV research, global AIDS assistance, or hepatitis C.

"The HIV Medicine Association is pleased that the president's fiscal year 2017 budget proposal largely sustains funding for domestic HIV/AIDS programs," said HIVMA chair Dr. Carlos del Rio. "However, we are disappointed that under his proposal investments in HIV research are flat-funded for the third year in a row, and that funding for the President's Emergency Plan for AIDS Relief once again has not seen an increase since peak funding in 2010. A robust federal response is more critical than ever to effectively respond to the HIV epidemic."

Obama's final budget request comes to \$4.1 trillion, a 4.9 percent increase over last year. While the Department of Health and Human Services gets about a quarter of that amount, more than 80 percent is committed to Medicare and Medicaid, leaving \$82.8 million in discretionary funds.

The budget allocates \$2.3 billion to the Ryan White Treatment Modernization Act, a modest \$34 million increase over FY 2016, including \$900 million for AIDS Drug Assistance Programs that pay for antiretroviral medications for people living with HIV.

The Centers for Disease Control and Prevention's National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis Prevention saw only a small increase, remaining at approximately \$1.1 billion (out of a total CDC budget of \$7 billion), and the \$788 million allocated for domestic HIV prevention and research stays about the same.

New this year is \$20 million for a demonstration project to improve access to PrEP for HIV prevention. Up to 30 percent of this amount may be used to pay for medication and associated lab tests.

The only FDA-approved PrEP drug, Truvada (tenofovir/emtricitabine), retails for about \$1,200 per month, but most Medicaid and some private insurance plans cover it, and manufacturer Gilead Sciences offers financial assistance programs.

Other domestic HIV funding comes through the Department of Veterans Affairs, which received a \$57 million increase for medical care for veterans living with HIV, and the Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS, or HOPWA, program, which is level-funded at \$335 million.

HIV research and global funding flat

The National Institutes of Health budget for medical research received a 2.5 percent increase overall – up to \$33.1 billion – but HIV research got no additional funding for FY 2017, leaving it at the same level as FY 2015 and FY 2016.

"This is a time of unprecedented promise in AIDS research, and flat-lining the NIH AIDS research budget for three years in a row threatens the many opportunities we have to end the epidemic as quickly as possible," Kenyon Farrow of the Treatment Action Group told the Bay Area Reporter. "There are many new and innovative studies underway in vaccine and cure research."

"Implementation of science research will help us address many of the disparities in prevention, treatment, and care we see in communities still largely impacted by the virus, particularly black gay men," Farrow added.

Funds for global HIV/AIDS efforts come from a variety of sources including DHHS, CDC, the U.S. Agency for International Development, and the Department of State, much of it consolidated under PEPFAR.

The FY 2017 budget provides a total of \$8.6 billion to combat HIV/AIDS, malaria, and tuberculosis, and address other global health issues. While this is \$73 million more than the 2016 allocation, most of the increase goes to malaria, maternal and child health, family planning, and vaccines, while HIV/AIDS itself saw no increase.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (\$1.3 billion), bilateral HIV/AIDS assistance to individual countries (\$4.3 billion), and UNAIDS (\$45 million) all received the same amounts as last year.

Hepatitis funding

The CDC's Division of Viral Hepatitis, funded at \$39 million, received a small \$5 million increase, which advocates say falls short given the large number of people with hepatitis B and C who do not know their status and are not receiving treatment.

"The president's budget fails the more than 5 million Americans living with hepatitis B or hepatitis C and the many more at risk for infection," said National Viral Hepatitis Roundtable Executive Director Ryan Clary. "The lack of funding and commitment to address hepatitis B and hepatitis C in a meaningful way, particularly given the exciting and sorely needed initiatives to combat the overlapping opioid, heroin, and overdose epidemics, is not simply disappointing – it is incredibly short-sighted."

However, the Ryan White budget includes \$9 million for a new program to expand hepatitis C screening and treatment for people with HIV. About a quarter of HIV-positive people are estimated to have hepatitis C and co-infection with both viruses leads to more rapid liver disease progression. In addition,

a portion of the increase in Veterans Affairs funding for medical care will go toward hepatitis C treatment.

"While we are pleased by the president's requests to invest \$9 million to support hepatitis C treatment for people living with HIV through the Ryan White program and \$1.5 billion for the VA to treat veterans living with hepatitis C, we need more comprehensive investments," Emalie Huriaux of Project Inform told the B.A.R. "Of the 60 nationally notifiable infectious diseases, hepatitis C-associated deaths are greater than the total number of deaths associated with the other 59 diseases combined."

Other health allocations

The DHHS budget proposal encourages reluctant states to expand their Medicaid programs under the Affordable Care Act by covering the full cost of expansion for three years regardless of when they start. About half of all HIV-positive people receiving medical care are covered by Medicaid, according to the Kaiser Family Foundation, and 16 states have not yet expanded Medicaid to low-income adults up to 133 percent of the federal poverty level.

The budget also includes several provisions to reduce the cost of prescription drugs, including allowing the Centers for Medicare and Medicaid Services to partner with states to negotiate lower prices, reducing the patent period for brand-name biologic drugs from 12 to seven years, increasing discounts for seniors who fall into Medicare's donut hole, or coverage gap, and requiring more price transparency from drug manufacturers.

Other notable health-related items in the FY 2017 budget include \$877 million to fight antibiotic resistance and develop new drugs, \$500 million to expand access to mental health services, and \$755 million for cancer prevention and treatment research – the so-called moonshot proposed in the president's recent State of the Union address. Obama also made a supplemental request for more than \$1.8 billion in emergency funding for Zika virus response.

In the area of sexual health for young people, the proposed budget eliminates all funding for "abstinence only until marriage" sex education programs.

Finally, the budget sets aside \$1.1 billion over two years to address a growing opioid addiction and overdose epidemic – mostly associated with heroin and prescription pain-killers – which has hit hard in rural areas. The initiative includes expanded medication-assisted addiction treatment using methadone or buprenorphine and increased access to naloxone to prevent overdose deaths.

This new allocation comes on top of \$400 million in opioid epidemic funding in a bipartisan budget agreement reached late last year, which also removed language banning the use of federal money for needle exchange programs.

"Expanded access to prevention and treatment of opioid abuse is critical to improving health outcomes for our patients with HIV with co-occurring substance use issues," said HIVMA's del Rio.

Experts consider it unlikely that the Republican Congress will approve Obama's FY 2017 budget request as a whole, but specific pieces could pass – such as the cancer moonshot – and it sets the groundwork if a Democrat is elected as the next president in November.

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

CDC Confirms HIV Transmission on Porn Set, and That's Just the Start

As reported by POZ | 2.12

“This is the first well-documented work-related HIV transmission among male adult film performers,” writes the Centers for Disease Control and Prevention (CDC) in a report published February 12 in the Morbidity and Mortality Weekly Report.

“A performer was infected by a non–work-related partner who was not aware of his HIV infection,” summarizes the report. “The performer, having tested negative...within the preceding 14 days, and unaware of his very recent HIV infection, infected another performer and a non–work-related partner. Viruses in all four HIV infections were highly genetically related, indicating a transmission cluster.”

The case refers to an incident reported in December 2014 that resulted in an Occupational Health Alert issued by the California Department of Public Health.

The CDC’s finding “puts truth to [the porn] industry’s testing lies,” claims the AIDS Healthcare Foundation (AHF) in a press release. AHF has backed a statewide bill in California to require all adult stars to use condoms on porn sets, but the group acknowledges to LA Weekly that it’s unclear whether the HIV transmission in question took place in Nevada or California. Indeed, LA Weekly reports that no California companies were involved in the case.

The AHF writes: “The new information published today in the MMWR report demonstrates that the Free Speech Coalition (FSC), the adult industry producers’ trade group, lies about its Performer Availability Screening Services (PASS) testing scheme and about HIV transmission in the adult film industry.”

The FSC, however, tells LA Weekly that “the CDC report refers to an incident from several years ago involving a out-of-state, non-compliant production in Nevada, where the industry testing protocols (known as PASS) were not observed. While AHF would like to claim otherwise, there is no comparison between shoots which used expired, non-uniform tests, and the industry’s comprehensive fourteen-day testing protocol.... No HIV transmissions have occurred on PASS-compliant sets in over a decade.”

In its press release, the AHF counters these FSC claims.

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

International study finds rectal microbicide gel safe when used daily and with sex

Participants as adherent to using gel with sex as taking a daily pill for HIV prevention.

As reported by Medical News Today | 2.25

A reduced glycerin formulation of tenofovir gel was found safe when used daily and around the time of sex, according to the first extended safety study of a rectal microbicide¹ for HIV prevention from anal sex. Presented at the 23rd Conference on Retroviruses and Opportunistic Infections (CROI 2016), the study, led by the U.S. National Institutes of Health (NIH)-funded Microbicide Trials Network (MTN), also

indicated that participants were as likely to follow through using the gel with sex as they were to using daily oral pre-exposure prophylaxis (PrEP) - a prevention strategy in which people who are HIV-uninfected take a daily pill to reduce their risk of infection.

The Phase II study, MTN-0172, began in September 2013 and enrolled 195 men who have sex with men (MSM) and transgender women at sites in Peru, Thailand, South Africa and the United States, including Puerto Rico. MTN-017 participants -12 percent of whom were transgender women - cycled through three study regimens which each lasted eight weeks: reduced glycerin tenofovir gel used daily, reduced glycerin tenofovir gel used before and after anal sex, and daily use of the antiretroviral tablet Truvada® (emtricitabine/tenofovir disoproxil fumarate), developed by Gilead Sciences, Inc. This design allowed researchers to collect information about the gel's safety and acceptability in the rectum, and compare it to the use of oral Truvada, which was approved for use as PrEP by the U.S. Food and Drug Administration in 2012.

Most side effects from study products in MTN-017 were minor, indicating the gel was safe, and there were no significant differences in adverse events among the gel regimens compared to oral Truvada. Overall, participants were highly adherent in MTN-017, with most following through in using their assigned products 80 percent of the time or more. Participants were similarly adherent to using gel before and after sex (93 percent) as they were to taking daily oral Truvada (94 percent). They were less adherent, however, when using the gel on a daily basis (83 percent). Adherence in MTN-017 was measured by a combination of responses to daily questions sent by text message, number of returned gel applicators and blood tests to confirm the presence or absence of drug.

When asked about preferences, participants reported they preferred oral Truvada to the gel, but found the before and after sex gel regimen as easy to use as oral Truvada. When asked about the likelihood that they would use the study products in the future, participants said that they would be as likely to use the gel before and after sex as they would to take oral Truvada. Forthcoming analyses from MTN-017 will shed light on how much drug was absorbed in the blood, rectal fluid and tissue, and assess whether use of the products caused changes in cells or tissue.

"The results from MTN-017 demonstrate there is a place for rectal microbicides used around the time of sex in future HIV prevention efforts," said Ross D. Cranston, M.D., associate professor, University of Pittsburgh School of Medicine, who led the study with Javier R. Lama, M.D., M.P.H., investigator and director, HIV Prevention Intervention Studies, IMPACTA PERU Clinical Trials Unit, Lima, Peru. "While we have more to learn from ongoing analyses of tissue and blood testing, the completion of this study was a significant undertaking and represents a major step forward in the development of a rectal microbicide for people at risk of HIV from anal sex."

MTN-017 was a larger follow-up trial to a previous study, MTN-0073, that found the reduced glycerin formulation of tenofovir gel was safe and acceptable to both men and women who used it in the rectum daily for a one-week period. The gel used in both studies was formulated with less glycerin to address gastrointestinal side effects experienced by some study participants who used an original vaginal formulation of tenofovir gel in an early study called RMP-02/MTN-0064.

"The MTN-017 findings come at a pivotal time in the field of rectal microbicides, setting the stage for future studies and complementing ongoing research into new products and delivery methods," said Ian McGowan, M.D., Ph.D., principal investigator of the MTN and professor of medicine, Division of Gastroenterology, Hepatology and Nutrition and Department of Obstetrics, Gynecology and

Reproductive Sciences, University of Pittsburgh School of Medicine. "Research is already underway at MTN to expand the pipeline of rectal microbicide products in order to find the right product to move forward into an effectiveness study."

Globally, racial and ethnic minorities, MSM and transgender women are disproportionately affected by HIV. Although most microbicide research has focused on products for vaginal use, the risk of becoming infected with HIV from unprotected anal sex may be 20 times greater than unprotected vaginal sex, in part because the rectal lining is only one-cell thick compared to the vagina's multiple layers.

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

Scientific Papers/Conference Abstracts

State variation in HIV/AIDS health outcomes: the effect of spending on social services and public health

Talbert Slagle KM, Canavan ME, Rogan EM, et al. *AIDS* 2016;20(4):657-663

Objective:

Despite considerable advances in the prevention and treatment of HIV/AIDS, the burden of new infections of HIV and AIDS varies substantially across the country. Previous studies have demonstrated associations between increased healthcare spending and better HIV/AIDS outcomes; however, less is known about the association between spending on social services and public health spending and HIV/AIDS outcomes. We sought to examine the association between state-level spending on social services and public health and HIV/AIDS case rates and AIDS deaths across the United States.

Design:

We conducted a retrospective, longitudinal study of the 50 U.S. states over 2000–2009 using a dataset of HIV/AIDS case rates and AIDS deaths per 100 000 people matched with a unique dataset of state-level spending on social services and public health per person in poverty.

Methods:

We estimated multivariable regression models for each HIV/AIDS outcome as a function of the social service and public health spending 1 and 5 years earlier in the state, adjusted for the log of state GDP per capita, regional and time fixed effects, Medicaid spending as % of GDP, and socio-demographic, economic, and health resource factors.

Results:

States with higher spending on social services and public health per person in poverty had significantly lower HIV and AIDS case rates and fewer AIDS deaths, both 1 and 5 years post expenditure ($P \leq 0.05$).

Conclusion:

Our findings suggest that spending on social services and public health may provide a leverage point for state policymakers to reduce HIV/AIDS case rates and AIDS deaths in their state.

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

Willingness to Disclose Sexually Transmitted Infection Status to Sex Partners Among College-Aged Men in the United States

Pfeiffer EJ, McGregor KA, Van Der Pol B, et al. *Sex Transm Dis* 2016;43(3):204-6

Abstract:

Disclosure of sexually transmitted infections (STIs) to sexual partners is critical to the prevention, treatment, and control of STIs. We examine personal intra and interpersonal influences on willingness to disclose STI status among college-aged men. Participants (n = 1064) were aged 17 to 24 years and recruited from a variety of university and community venues. Using independent-samples t test, Pearson χ^2 test, and binary logistic regression, we examined the relationship between willingness to disclose an STI and intrapersonal and interpersonal factors, including age, masculinity values, interpersonal violence, partner cell phone monitoring, alcohol and/or drug use, condom use, number and characteristics of sex partners, and previous STI. Results reveal that among college-aged men, type of sex partner and masculinity values are significant variables in predicting whether or not an individual is willing to disclose. These data can inform STI control programs to more effectively address the complex issues associated with STI disclosure to sex partners.

View the paper online: [Abstract](#)

Predictors of Human Papillomavirus Vaccination Among Young Men Who Have Sex With Men

Gerend MA, Madkins K, Phillips G, et al. *Sex Transm Dis* 2016;43(3):185-191

Background:

Human papillomavirus (HPV) is a common sexually transmitted infection that causes anal, penile, and oropharyngeal cancers in men. Men who have sex with men (MSM) are at particularly high risk for HPV infection and HPV-related disease. Human papillomavirus vaccination is currently recommended for all MSM in the United States through age 26 years, yet little is known about HPV vaccine uptake in this population. The purpose of this study was to identify predictors of HPV vaccine uptake and barriers and facilitators to HPV vaccination that may be unique to young MSM.

Methods:

Men aged 18 to 26 years (n = 336) were recruited via advertisements placed on a geospatial smartphone dating application designed for MSM. Participants completed an online survey. Correlates of vaccine uptake and provider recommendation for HPV vaccine were identified using logistic regression.

Results:

In total, 21% of participants had received at least 1 dose of HPV vaccine. Provider recommendation was the strongest predictor of uptake such that MSM with a recommendation were more than 40 times more likely to have been vaccinated. Additional predictors of uptake included age and HPV vaccine attitudes. Predictors of provider recommendation included sexual identity, race/ethnicity, condomless anal sex, and HIV status. Psychosocial correlates and barriers and facilitators to HPV vaccination among unvaccinated men were also identified.

Conclusions:

Findings highlight potential disparities in HPV vaccine uptake, as well as disparities in provider recommendation practices for HPV vaccination. Future interventions should aim to clarify misconceptions, modify psychosocial beliefs, and address barriers and facilitators to HPV vaccine uptake specific to young MSM.

View the paper online: [Abstract](#)

Recent Biomarker-Confirmed Unprotected Vaginal Sex, But Not Self-reported Unprotected Sex, Is Associated With Recurrent Bacterial Vaginosis

Turner AN, Carr Reese P, Snead MC, et al. *Sex Transm Dis* 2016;43(3):172-176

Background:

Self-reported unprotected vaginal sex seems to increase risk of bacterial vaginosis (BV). However, the validity of self-reports is questionable, given their inconsistency with more objective measures of recent semen exposure such as detection of prostate-specific antigen (PSA). We examined whether recent unprotected sex, as measured both by PSA detection on vaginal swabs and by self-report, was associated with increased BV recurrence.

Methods:

We analyzed randomized trial data from nonpregnant, BV-positive adult women recruited from a sexually transmitted disease clinic. Participants received BV therapy at enrollment and were scheduled to return after 4, 12, and 24 weeks. Bacterial vaginosis (by Nugent score) and PSA were measured at each visit. We used Cox proportional hazards models to examine the association between PSA positivity and recurrent BV. We also evaluated associations between self-reported unprotected sex (ever/never since the last visit and in the last 48 hours, analyzed separately) and recurrent BV.

Results:

Prostate-specific antigen and BV results were available for 96 women who contributed 226 follow-up visits. Prostate-specific antigen positivity was associated with increased BV recurrence (adjusted hazard ratio [aHR], 2.32; 95% confidence interval [CI], 1.28–4.21). In contrast, we observed no significant increase in BV recurrence among women self-reporting unprotected sex since the last visit (aHR, 1.63; 95% CI, 0.77–3.43) or in the last 48 hours (aHR, 1.28; 95% CI, 0.70–2.36).

Conclusions:

Estimates from earlier studies linking self-reported unprotected sex and BV may be biased by misclassification. Biomarkers can improve measurement of unprotected sex, a critical exposure variable in sexual health research.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

Highlights from the Conference on Retroviruses and Opportunistic Infections 2016

The annual [Conference on Retroviruses and Opportunistic Infections](#) (CROI 2016) took place in Boston, Massachusetts earlier this week at the Hynes Convention Center. CROI is the premier international venue for bridging basic and clinical investigation to clinical practice in the field of HIV and related viruses. Top scientists, clinicians, and policy makers from around the world had the opportunity to share with each other the latest studies, important developments, and best research methods in the ongoing battle against HIV and AIDS and related infectious diseases.

CDC scientists presented more than 40 abstracts that highlighted new HIV research findings and its implications for HIV prevention efforts across the nation. Symposium and plenary lectures, workshops, themed discussions, and oral presentations are available online as [webcasts](#). Electronic posters will be accessible to download next week. You can also follow CDC highlights from CROI on Twitter [@CDC_HIVAIDS](#) or #CROI2016 to see conversations from this year's conference.

HIV & AIDS in the United States Update: Web Update

The Right Way to Use a Male Condom

Using male condoms the right way, every time, can reduce (though not eliminate) the risk of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and viral hepatitis, as well as other diseases that may be transmitted through sex like Zika virus and Ebola. Using male condoms the right way, every time, can also help prevent pregnancy.

[The Right Way to Use a Male Condom](#)

This page contains sexually graphic images and may not be suitable for some audiences.

Things You Can Do To Commemorate National Women and Girls HIV/AIDS Awareness Day March 10

CDC's Division of HIV/AIDS Prevention

1. Learn the Basics
[Learn the basics](#) about HIV and AIDS. Today, more tools than ever are available to prevent HIV. In addition to limiting your number of sexual partners, never sharing needles, and using condoms correctly and consistently, you may be able to take advantage of medicines that prevent and treat HIV, including [pre-exposure prophylaxis \(PrEP\)](#), [post-exposure prophylaxis \(PEP\)](#), and [antiretroviral therapy \(ART\)](#).
2. Get Tested and Encourage Others to Get Tested, too.
Are you Doing It? Testing for HIV? CDC recommends that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care and that people with certain risk factors get tested more often. After you have learned the basics about HIV testing, you can find a testing center in your area.
 - Use our Doing It website to find a testing site

- Text your ZIP code to “KNOW IT” (566948)
 - Call 1-800-CDC-INFO
 - Talk to your doctor or health care provider
 - Take a home HIV test
3. Follow Us on Social Media
- Follow CDC social media accounts that promote HIV prevention and testing, and share and retweet messages**
- CDC Facebook: [Act Against AIDS](#) and [CDC HIV](#)
 - Twitter: [@TalkHIV](#) and [@CDC_HIVAIDS](#)
 - Pinterest: [Preventing HIV and STDs](#)
 - Instagram: [Act Against AIDS](#)

Other federal partners

- Follow AIDS.gov on [Facebook](#), [Twitter](#), and [Instagram](#).
 - Follow the Office of Women’s Health on [Twitter](#), [Facebook](#), and [You Tube](#).
 - Like the U.S. Department of Health & Human Services on [Facebook](#) and follow on Twitter [@HHSgov](#).
4. Promote HIV Prevention for Women and Girls on Social Media.
- Use the hashtags **#NWGHAAD** and **#BestDefense** to spread awareness day messages about HIV prevention on social media. Here are a few samples:
- *Mar. 10 is Nat’l Women & Girls HIV/AIDS Awareness Day – What’s your #BestDefense to prevent HIV? #NWGHAAD #DoingIt*
 - *The #BestDefense is a Good Offense! Learn how to [protect yourself](#) and your partner from #HIV*
 - *#NWGHAAD #DoingIt*
 - *#DoingIt! Empower the [women](#) in your life to get tested for #NWGHAAD It’s their #BestDefense*
 - *On #NWGHAAD, [get tested](#). #DoingIt #BestDefense*
 - *The #BestDefense is knowing your protection options. Learn if [PrEP](#) is right for you #NWGHAAD #DoingIt*

Continue the online conversation with Act Against AIDS on [Facebook](#), [Twitter](#), and [Instagram](#).

5. Get Involved
- The theme for NWGHAAD is “The Best Defense Is a Good Offense” – The Office on Women’s Health is encouraging women and girls to use their best defense against HIV by:
- practicing safe sex
 - getting an HIV test
 - avoiding abuse of drugs and alcohol
 - talking to their doctors about PrEP and PEP if they may be at risk.

Join [Partnering and Communicating Together \(PACT\) to Act Against AIDS](#) organizations in helping to prevent HIV among women.

The Office on Women’s Health is hosting a NWGHAAD Walk in Washington, DC on Thursday, March 10 from 11:45am–1:30pm. Encourage local organizations, community partners, colleges, and sororities to host their own NWGHAAD walks.

Or host an NWGHAAD event in your community. Find important resources and information at <http://www.womenshealth.gov/nwghaad/>.

Job/Internship Postings

Health Policy and Health Services Research Program Officer - CHRP

Organization: CHRP
App. Deadline: March 7

Job Title: Health Policy and Health Services Research Program Officer

Job Description: This position has primary responsibility in the area of health policy and health services research in the California HIV/AIDS Research Program (CHRP), including program development and planning, peer reviewer and applicant relations, grant application and award management, and representing the program and disseminating research findings to a broad range of organizations and institutions concerned with HIV/AIDS-related issues. This position also serves as the primary CHRP liaison to the RGPO Communications and Dissemination Center of Excellence (COE), maintaining expertise and contributing to innovation in research dissemination, including collaborative development of dissemination procedures and tools. Please view the job listing and submit an application through the University of California, Office of the President.

Organization Description: CHRP staff are members of the Research Grants Program Office (RGPO) within the Office of Research and Graduate Studies (ORGS). The RGPO consists of several grant-giving programs that are administered by the University for the University of California or on behalf of the State of California. These programs are the California Breast Cancer Research Program, the Tobacco-Related Disease Research Program, the California HIV/AIDS Research Program, and the UC Research Initiatives such as the Multicampus Research Programs and Initiatives and the Lab Fee Research Program. The RGPO provides central administrative units to support grant review and administration, financial and budgetary services, database management, and other core administrative needs to all of the grant programs. These services are provided by the Grants Budget, Finance and Administration Unit and the Contract and Grants Unit.

Required Skills:

1. Earned doctorate degree in a relevant area of health policy, health services research, social/behavioral sciences, public health, or political science. Ten years of relevant experience required, with at least three in research in the field of the degree, or an equivalent level of education and experience.
2. In depth academic background and experience in selected area of research including record of publications in related field(s) required.
3. Extensive knowledge and understanding of issues in disease-related research program management, science and health policy, and research program evaluation. Demonstrated knowledge of and experience related to the translation and dissemination of research findings to applied, community or commercial uses. State-of-the-art knowledge of health policy and health services research, particularly in relation to HIV/AIDS.
4. Skill in analyzing information, problems, situations, policies, or procedures to define the problem, need or objective, identifying relevant issues or concerns, formulating alternatives for resolution or new

program development, and recommending alternative choices and implications for implementation. Proven ability to formulate solutions, new program development, alternative choices and implications for implementation.

5. Advanced interpersonal skills and ability to work with diverse groups to achieve results. Demonstrated experience and commitment to working in collaborative teams and in positions with shared authority for accomplishing program goals.
6. Demonstrated ability to work collaboratively with internal and external peers, managers and teams. Ability to establish and maintain cooperative and mutually supportive working relationships with faculty, administrators, staff, other campus units, UC system units and sponsoring agencies.
7. Advanced program planning and management of projects.
8. Demonstrated excellent written and oral communication skills to ensure effective communication with a wide audience (e.g., scientists, staff, industry, community agencies, funding agencies and the general public). Advanced skills analyzing information, problems, situations, policies or procedures to define the problem, need or objective.
9. Proven leadership ability in scientific program planning and management of projects; experience leading scientific committees, outreach and technical assistance teams, peer review committees, and internal and external staff.
10. Incorporate effective listening skills. Maintain a positive attitude.

Preferred Skills:

1. Conduct of research in HIV/AIDS and a record of publications in the field.
2. Experience as program or grant officer managing a multi-million dollar research portfolio.
3. Knowledge of UCOP research policies, documents and bulletins, grant management database systems, UCLA business and finance policies and bulletins, and/or the UCLA Accounting policies and procedures.

Application Deadline/Closing Date: Monday, March 7, 2016

How to Apply:

The job/organization description is listed on the CHRP website: <http://www.californiaaidsresearch.org/about/job-opportunities.html>

Applicants should submit applications through the University of California, Office of the President employment

site: <https://jobs.ucop.edu/applicants/jsp/shared/frameset/Frameset.jsp?time=1456429403878>

Aaron Kavanaugh
Office of Policy, Planning, and Communications

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

Tel: 510-620-3402

Fax: 510-620-3180

Web: std.ca.gov

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