

The CAB Bulletin

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HIV Vaccines and the Community

Participants' Bill of Rights and Responsibilities

By Renee Holt, Regulatory and Clinical Affairs Manager

I am happy to announce that the new version of the Participant's Bill of Rights and Responsibilities (PBORR) has been approved by all interested parties. This newest version of the PBORR reflects several years of hard work by members of the Global CAB's (GCAB's) Ethics Working Group (EWG). Initially introduced into the Network in 2001, the PBORR has always been meant to function as a living document that could change as needed. The EWG has spent the past few years working on several improvements, and has coordinated with DAIDS on clarifying study-related injury plans. Late last summer, the EWG was able to submit to the GCAB a final proposal for PBORR changes. The GCAB voted to adopt the new version at the beginning of this year, and the new PBORR was then submitted to the HVTN's Scientific Steering Committee, which also approved the changes. After a final DAIDS review, I am pleased to inform everyone that the new PBORR is being translated and distributed to sites!

Beginning this year, protocols refer to the PBORR in the informed consent process; how each site decides to include the PBORR into the process is up to it. A working group from the EWG is conducting a survey of PBORR use at the sites, and will conduct a second survey next year determine whether there are any changes in PBORR use. They will be contacting GCAB representatives soon with more information about this survey.

Thanks to all the hard work from the EWG members!

Please see page 4 for the full text of the PBORR. ☘

The next seven years

The HVTN is beginning a new phase. The announcements have now been made regarding the next funding cycle for AIDS-related trials networks funded by the US government. We know which sites we will be working with and who our partners will be as we move towards finding effective HIV prevention and treatment options for the world.

We are happy to welcome three new sites into the HVTN, one from Europe and two from the US: Lausanne, Switzerland; Atlanta, Georgia; and Raleigh, North Carolina. We look forward to meeting our new coworkers from these sites.

The HVTN will maintain its commitment to community involvement as we undertake the challenges of advancing current products through trials; work to monitor the effect of our study vaccines on those who seroconvert; take on the challenge of including adolescents in HIV vaccine trials; continue to develop the pipeline with potential vaccine candidates; and strive towards more effective and nimble assays to allow us to measure the immune system's reaction to the study vaccines.

For more information about network funding, please visit the website <http://www3.niaid.nih.gov/news/newsreleases/2007/ctu07.htm>. ☘

Step Study enrolled!

For those of you who haven't heard the exciting news, the Step Study has been fully enrolled! The HVTN finished at the end of January with 2008 participants enrolled, and Merck reached a total of 3000 enrolled in Step Study in March. The focus is now on issues of retention priorities and methods. Maintaining interest from the participants who were enrolled over the long course of the trial will be a challenge, especially for those sites whose experience has been in shorter phase I trials.

An amendment is planned for the Step Study, which will involve extending follow-up for those who seroconvert during the course of the trial. More detailed information is forthcoming.

As the Step Study moved to the next stage, HVTN 503 (Phambili) began in South Africa. See page 3 for more information on the Phambili trial. ☘

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Top: CAB members John Bunting, Butch McKay, David Crawford, Udom Likhitwonnawut, Cheryl Lopes, and Stephan Oxendine gather at the fall HVTN Conference. Bottom: An education session for parents in Haiti, led by CAB members.

Protocols Currently Enrolling

Protocol number	Developer	Product design	Sites	Number of participants	Notes
HVTN 063	Wyeth	DNA	Harvard, New York, Rochester, Sao Paulo	120	Enrollment expected to be finished in May
HVTN 065	GeoVax	DNA/MVA	Birmingham, Maryland, Rochester, St. Louis, Nashville	146	Part A enrollment completed Part B expected to begin in June
HVTN 069	VRC	DNA/ Adenovirus 5	Birmingham, Harvard, New York, Seattle, Iquitos	90	ongoing
HVTN 503	Merck	Adenovirus 5	Soweto, Cape Town, Klerksdorp, Pretoria, Durban	3000	Pretoria and Durban sites expected to begin in June

Protocols in the field

Protocol number	Developer	Product design	Sites	Number of participants	Notes
HVTN 049	Chiron/ NOVAD	DNA/protein	Harvard, Seattle, St. Louis, Nashville	96	Completing follow-up visits
HVTN 055	Therion	MVA/FPV	Birmingham, Rochester, Seattle, St. Louis, Rio, Sao Paulo	150	Vaccinations discontinued due to Therion shutting down
HVTN 060	Wyeth	DNA	Birmingham, Maryland, Nashville, Chiang Mai	144	Completing vaccinations and follow-up visits
HVTN 064	Pharmexa/ Epimmune	Protein/DNA	Baltimore, Rochester, San Francisco	84	Group 4 continuing to receive vaccinations. Groups 1-3 & 5 are discontinued due to labeling issues
HVTN 068	VRC	DNA/ Adenovirus	Birmingham, New York, Rochester, San Francisco, Seattle, Nashville	66	Continuing follow-up visits
HVTN 204	VRC	DNA/ Adenovirus	Birmingham, Boston, Baltimore, Rochester, Nashville, Cape Town, Port-au-Prince, Kingston, Klerksdorp, Rio, Sao Paulo, Soweto	480 (180 US, 300 non-US)	Completing vaccinations and follow-up visits
HVTN 502 Step Study	Merck	Adenovirus 5	HVTN sites: Seattle, San Francisco, St. Louis, Chicago, Rochester, Boston, New York, Birmingham, San Juan, Kingston, Port au Prince, Santo Domingo, Iquitos, Lima, Sao Paulo, Rio, Merck sites: Vancouver, Los Angeles, Denver, Houston, Toronto, Montreal, Newark, Atlanta, Miami, Sydney, Sao Paulo, Santo Domingo	3000	Continuing to vaccinate and follow-up

Getting ready for the Phambili Trial

In January 2007, the HVTN launched the Phambili trial (HVTN 503). Conducted in South Africa, Phambili is a phase 2b trial of the Merck Adenovirus study vaccine that is also being tested in the phase 2b Step Study (HVTN 502). Phambili will allow researchers to answer questions about how a product made from a clade B virus works in an area where clade C is more common.

Phambili means “moving forward” in Xhosa and Zulu, which corresponds with the idea that the trials we conduct are steps that we take along the path to finding an HIV vaccine. This trial is very exciting, as it is the first efficacy trial to take place in South Africa. Enrollment began in January and has enrolled approximately 100 people as of the middle of April, 2007. The Soweto, Cape Town, and Klerksdorp sites are all enrolling. The Pretoria and Durban sites will begin to enroll soon.

At the beginning of January, the HVTN Training Program held an efficacy Trials training workshop in Pretoria, South Africa, in preparation for Phambili’s launch.

The five HVTN South African site staff attended and facilitated the training workshop along with HVTN and DAIDS staff. The training involved site investigators, clinicians, educators and recruiters. This was the third efficacy trials workshop sponsored by the HVTN over a 12 month period, and the first to involve such a large and broad variety of attendees and facilitators.

The first part of the training workshop focused on reviewing the lessons learned from other large-scale HIV prevention studies. Quality management planning was a part of the curriculum, with a focus on regulatory issues as well as plans to integrate an instructional video designed to enhance the informed consent process.

During the second part of the training, special emphasis was placed on recruitment strategies and how social and behavioral risk for enrollees can be reduced through effective counseling. The workshop curriculum also included sessions about contraceptives counseling/provision and clinical care for volunteers who will become infected with HIV during the course of the trial. Thanks to everyone who participated for a great start to Phambili! ☘

Updates on upcoming trials

PAVE 100

We’re gearing up for PAVE 100, a multi-network phase 2b trial of the VRC DNA/rAd5 to be conducted in three regions of the world: the Americas, East Africa, and Southern Africa. Anticipated to start in the second half of 2007, PAVE 100 will test the product that is currently being tested in HVTN 204 in collaboration with IAVI (the International AIDS Vaccine Initiative), the CDC (Centers for Disease Control) and the USMHRP (US Military HIV Research Program). ☘

Adolescent trials

Work is underway preparing for two adolescent trials. One is intended for South Africa, and the other for both US and non-US sites. Establishing the protocols and implementing the trials will take considerable coordination and effort from Core, site staff, and CAB alike. We will continue to update you about these trials as work on them progresses. Note that Linda Sawin and Phineas Malahlela are the CAB representatives on the Adolescent Trials Coordinating Group. ☘

Phase 1 trials

Several trials are set to begin this summer. HVTN 067 is a trial of a DNA/MVA product. HVTN 071 will be looking at the Merck Ad5 product to assess the best assays (tests) to use; it is set to begin in later summer. Also starting in late summer should be HVTN 072, which will compare Ad35 and Ad5 vaccine products. HVTN 070 is expected to begin in fall, and it will investigate a DNA plasmid product with a cytokine adjuvant. ☘



Photos from the efficacy trials training in South Africa, from top: Danna Flood, Chief, HVTN Training Unit, speaks to training participants; Renee Holt hugs her favorite book — the HVTN Manual of Operations; Georgina Wessie, Community Educator from Klerksdorp, listens to Peggy Modikoe, the educator from the new Durban site.

Participant's Bill of Rights and Responsibilities (PBORR)

This document provides a short list of the rights and responsibilities you have while you participate in an HIV Vaccine Trials Network (HVTN) trial. See the study informed consent form for more information.

Rights As a participant in an HVTN study, you have the right to:

Have all known information, including potential risks and benefits of study participation, presented to you in a way you can understand. You will be told about any new information learned during the course of the study.

Refuse to join the study or decide to leave the study at any time. You can also refuse to join any follow-up studies you are told about. You will not lose any of the rights referred to in this document if you refuse to join the study or leave the study.

A discrimination-free study environment. Your personal choices, values, beliefs, and cultural context will be respected by the people running the study.

Referral to available counseling and support services for issues related to the study and HIV prevention.

Referral to available counseling, support, medical, and treatment services for illnesses you suffer during the study, including HIV.

Assistance resolving study-related social problems and/or discrimination. With your permission, we can talk to the people you ask us to contact to explain more about your participation in the study.

Treatment for physical injuries, should they occur, for any injury more likely to be related to study products or procedures than to any other cause, to the extent described in the study consent form. There are funds to pay for treatment of these injuries. A group that reviews safety issues for the study makes the determination of relatedness. You can have the decision reviewed if you disagree. In some cases, the funds may not be enough to cover full treatment. The groups involved in the study will seek more funds if needed, but cannot guarantee them. Your study staff will provide more information on this issue and will answer any questions you may have or put you in touch with the person most qualified to answer your questions.

Free and accurate testing for HIV infection during the study. If, at the end of the study, you have a positive HIV test that is caused by the study vaccine and not by HIV infection, you can receive follow-up testing at the study clinic until the test becomes negative.

Assistance in meeting study commitments. A list of the items that are available to you will be provided by your study site.

Confidentiality. Communications and records about you and your participation in the study will be shared only as needed to conduct the study, or as required by law. See your study site's informed consent form for more information.

Be offered a study identification card that shows that you are in the study. This optional card will include the phone number and/or address of a person who can provide additional information.

Maintain your legal rights. As a trial participant, you are not waiving any of your rights.

Be told whether you received a placebo or a vaccine when the study ends, or when medically necessary.

Be updated about progression of studies, told when study results may be available, and told how to learn about the results.

Responsibilities As a participant in an HVTN study, you have the responsibility to:

Review and demonstrate an understanding of all the materials given to you, including the informed consent documents. Ask for explanation about any information you do not understand before you consent to participate in the study. You can also ask questions anytime during the study.

Make an informed decision about whether to participate in this study after weighing the risks and benefits. It is important to know what the study is about. The staff will assist you in this. If it helps you to make a decision, talk to people you trust and respect about whether joining the study is right for you.

Tell study staff as soon as possible if you experience discrimination and/or social harm that you think may be related to your trial participation.

Do not give blood or donate organs or other body fluids during the study.

Get your HIV testing done only at the study site as long as the study lasts. Talk to the study staff if you have to get tested elsewhere.

If you are able to get pregnant, avoid pregnancy during the study by using effective birth control methods. The staff will review effective birth control methods with you.

Keep your study appointments. Tell study staff as soon as possible if you need to reschedule an appointment.

Treat study staff with respect.

Keep confidential the participation of others in the study.

Give the study staff complete and accurate study-related information. Tell the study staff about any changes in your contact information or health information.

Follow the instructions of the study staff to the best of your ability. Work together with the study staff to maintain your health and safety during the trial.

Tell study staff as soon as possible if you are unable to continue or if you decide to stop your study participation.

The Network Evaluation Subcommittee: update

by Katy Turner, Chief, Network Evaluation

The Network Evaluation Subcommittee (NES) recently completed its annual assessment of the HVTN to evaluate how well the Network is achieving its priorities. Evaluation helps tell us whether we are producing valid, reproducible and timely data that will support FDA licensure of potential vaccine products. The NES works to help document program effectiveness, improve the program, inform decision making, and demonstrate accountability. This year, the NES focused on the life of a protocol from concept to publication. The NES identified several areas of success, but also found activities that need improvement.

Network successes:

- The HVTN continues to shorten protocol development time. The median time for protocol development was 3.7 months, a reduction of 2.5 months from previous years.
- During the evaluation period, feedback from the FDA on protocols only resulted in changes to 3 of 11 protocols.
- Targets for enrollment were developed and all but one study enrolled 100% of the expected rate (that one enrolled 97.6% of the expected rate).
- Overall, the Network was successful in recruiting diverse populations.
- Fourteen site-affiliated labs processed more than 3,000 specimens.
- In the Seattle Core office, the HVTN streamlined internal protocol implementation, improved enrollment tracking/reporting, and increased the efficiency of meetings.

Areas for improvement:

- Getting studies into the field and open continues to be a challenge: 38% of US sites missed the 120-day target for site activation, and implementation of studies at non-US sites took over a year.
- Planned holds that are written into the protocol continue to prolong enrollment. Seven of nine studies had no planned holds. Among the studies with planned holds, the percent of

enrollment time spent on hold ranged from 23% to 69%.

- For the first time, the NES assessed discontinuations of vaccination (DOV) as a measure of retention and data quality. They found that there was a 10.6% cumulative DOV rate across the HVTN and 4 of 11 protocols had an even higher rate of DOVs. To maintain statistical targets, DOVs need to account for less than 10% of lost data.
- Once a study is complete and the last participant visit has occurred, there are few triggers or processes in place to initiate analysis of data, the production of a final study summary, and the drafting of a paper.

The ongoing, critical self-evaluation provided by the NES allows the HVTN to identify areas for improvement quickly and make changes as needed. After reviewing the results of this recent evaluation, HVTN leadership stresses that it is a Network priority to improve protocol implementation and get our studies into the field faster. The NES will focus more closely on protocol implementation during the site evaluation, with the goal of pinpointing roadblocks and identifying strategies to improve implementation. If you have questions please contact Katy Turner, Chief of Network Evaluation, at ktturner@hvtn.org. ☘



Brad Fischer, Katy Turner, and Denise Urness of the Network Evaluation Unit.



Dear CAB members,

As many of you know, Andrew Lambert has left the HVTN to move to Cape Town, South Africa. He will be working for the International Partnership for Microbicides, helping to coordinate their community activities throughout Africa. Andrew has longed to return to Africa full-time for years, and this opportunity was an exciting new venture, despite the challenges he had in leaving the HVTN and all the people in it.

Andrew contributed considerably to the HVTN over the years. One of the first staff members who joined the Network, Andrew pioneered the HVTN's initial site outreach, training and coordination work. He has been a force in development of trainings, in assembling the comprehensive Training Manual, and in setting the standard for international communication that the HVTN strives for.

The HVTN will continue to draw on the work that Andrew has accomplished during his time with us, and we wish him well as he undertakes new endeavors. Don't be surprised if some of you cross paths with him down the road.

With thanks,

Dr. Lawrence Corey
Principal Investigator, HVTN

The cutting edge: male circumcision and HIV prevention

By Gaston Djomand, Director of Scientific Communication

The origins

Male circumcision may have begun as a religious sacrifice, a rite of passage marking a boy's entrance into adulthood, a form of sympathetic magic to ensure virility, a means of increasing or decreasing sexual pleasure, a method to help with cleanliness, a means of marking those of lower (or higher) social status, means of differentiating a circumcising group from their non-circumcising neighbors, a means of discouraging socially prohibited sexual behaviors, a symbolic castration, a demonstration of one's ability to endure pain, or a male counterpart to menstruation.

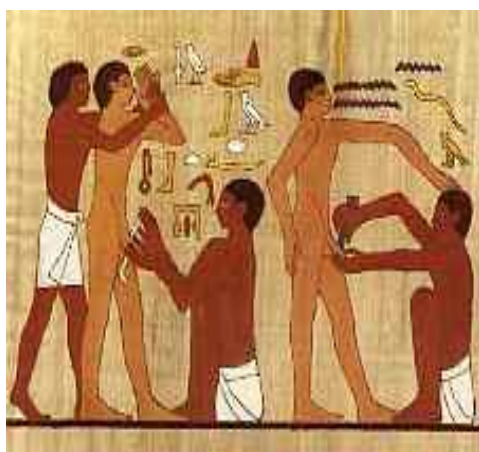


Fig 1: An ancient Egyptian relief representing circumcision ceremony.

The oldest evidence for circumcision comes from Egypt. Circumcision varies by geographical regions. In some African tribes, circumcision is performed at birth. In Judaic societies, the ritual is performed on the eighth day after birth. For Moslems and many of the other tribal cultures, it is performed in early adult life as a rite of passage, (like puberty or marriage). Over the past few years, several observational studies have shown that uncircumcised men are at greater risk for HIV infection and other sexually transmitted diseases. In Sub-Saharan Africa, HIV prevalence seems lower in countries where more than 80% of men are circumcised compared to countries where fewer than 20% of men are circumcised (see Figure 2).

A pivotal moment in HIV and AIDS prevention

Recent data from three randomized clinical

trials show that populations that are circumcised also have significantly reduced risks of HIV acquisition among men in heterosexual relationships (between 48% and 53% reduction). There is still much debate and research about the topic in the medical community, however.

The first randomized controlled trial, published in November 2005, found a 60% reduction in the rate of new HIV in the intervention group. Two further randomized trials of the effect of circumcision on HIV infections conducted in Uganda and Kenya were originally scheduled to be completed in 2007. However, the US NIAID halted the trials on December 13, 2006 after Data and Safety Board recommendations, because circumcision was so effective that it would be unethical to continue the experiment and not offer circumcision to the uncircumcised men who were acting as controls. The results showed that circumcised males in Uganda were 53% less likely to get infected with HIV and circumcised males in Kenya were 48% less likely to get infected.

A possible mechanism relates to Langerhans cells in the foreskin. Langerhans cells may provide an entry point for viral infection. Three studies identified high concentrations of Langerhans and other HIV target cells in the foreskin. Additionally, the skin on the foreskin of uncircumcised men is thin, which increases the chance of small tears in the skin. Any break in the skin allows viruses to enter the bloodstream more easily. Perhaps for the same reason, there seem to be higher rates of sexually transmitted genital ulcerative (open sores) diseases in uncircumcised men. These sores may also increase their susceptibility to HIV infection.

Interpretation of the results

The three randomized clinical trials conducted in Africa provide conclusive evidence of the effectiveness of male circumcision in reducing men's risk of acquiring HIV through heterosexual contact in areas with high HIV

prevalence. Reducing risk is different than offering protection, however. Circumcision does not protect anyone from HIV infection, and it must be presented as just one factor in a comprehensive prevention strategy. Partner reduction, correct and consistent use of condoms, and delay of sexual debut should be part of any comprehensive prevention strategy regardless of circumcision status.

A study in Kenya looking at behavior after circumcision showed that circumcised men did not engage in more risky behavior than uncircumcised men one year post-circumcision. This finding suggests that the protective effect of male circumcision on HIV acquisition is unlikely to be offset by an adverse behavioral impact.

These trials to date have looked only at heterosexual risk of HIV transmission from females to males. Associated risks with other modes of transmission, such as male-to-male transmission, male-to-female sexual transmission and needle sharing are not addressed in these studies. A separate clinical trial led by researchers at Johns Hopkins University indicates that is possible that male circumcision can increase HIV acquisition by women due to sexual activity occurring before wounds have healed, thus increasing opportunity for transmission of virus.

The findings from these studies conducted in Africa may have less impact on the epidemic in the US for various reasons. First, the prevalence of HIV is lower in the US. Moreover, most infections among men in the US occur in men who have sex with men (MSM). The amount of benefit provided by circumcision in MSM unknown. Lastly, whether the effect of male circumcision differs by HIV-1 subtype, predominantly subtype B in the US and subtypes A, C and D in sub-Saharan Africa, is also unknown.

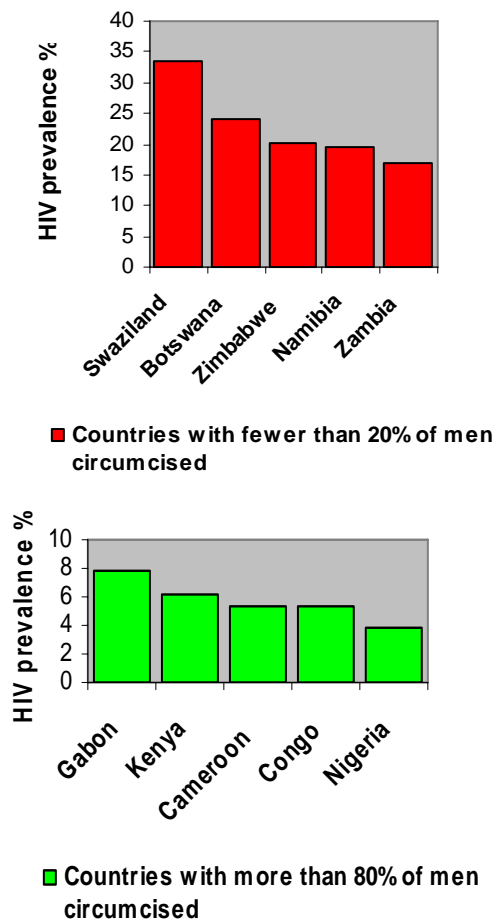
How to deliver and rollout implications

Unlike most AIDS prevention strategies, male circumcision is a procedure recognized risks, requiring trained personnel, sterile instruments and supplies. When improperly performed, serious complica-

tions may arise. These complications are usually due to situations in which there was poor training of those performing circumcision, lack of appropriate equipment and/or lack of follow-up. In addition to the technical aspects, the penis requires some time to heal and during that time there is a disruption of the surface of the penis. As is indicated by the follow-up study regarding infection rates of women with circumcised partners, this incision area may make a point of entry for HIV infection, thus increasing the risk of HIV infection. Good counseling and adherence would be necessary to any rollout program.

Cultural and religious beliefs, rituals and attitudes towards circumcision will play a critical role in the acceptability of male circumcision for HIV prevention in both communities who practice circumcision and those who do not. For instance, male circumcision in East Africa is a rite of passage from childhood to adulthood but is

Figure 2: Circumcision and HIV prevalence in Sub-Saharan countries



only practiced in some tribes (Kikuyu and Maasai tribes) of Kenya and Tanzania. Some other tribes in East Africa do not practice male circumcision (e.g., the Luo of western Kenya) and there is no incidence of child circumcision in indigenous tribes of this part of the world. Additionally, there are groups around the world that are opposed to male circumcision; this opposition may significantly affect any plans for implementation of male circumcision as an HIV prevention strategy.

At the individual and community level, efforts should be made to publicize male circumcision as an additional prevention measure, rather than a replacement for male and female condoms and other risk reduction strategies. At the provider and programmatic level, there needs to be the involvement of traditional male circumcision practitioners in order to standardize and define the best practices. Any approach should be coordinated to ensure synergy across counseling, surgery, and follow-up for adverse events. From a policymaker perspective, a comprehensive and forward-looking approach to AIDS prevention should be initiated and this includes participation of key stakeholders and the community at large (NGOs, CBOs, PWA organizations) through intense consultations to discuss resources and country preparedness for implementation of safe male circumcision.

UNAIDS and WHO are working with stakeholders in several countries to conduct needs assessments to help prepare for any change in policy resulting from these studies. For more information about international response to the circumcision studies, visit the WHO website at www.who.int/hiv and the UNAIDS website at www.unaids.org

Impact on other prevention efforts

The partially protective effect of male circumcision in preventing acquisition of HIV is terrific news in the field of AIDS prevention. However, these studies bring new challenges for trial sponsors, especially in the field of HIV prevention. First, including male circumcision in research protocols as an ethical part of a comprehensive prevention strategy may significantly increase the cost and length

of trials. Also, the number of adverse events and, potentially, the sample size of the trials is a concern, as fewer infections would be anticipated in a circumcised population. In addition, ethical discussions may arise about participation in trials to benefit from circumcision.

In January 2007, HVTN launched a phase 2b test-of-concept study to evaluate Merck’s Adenovirus vaccine in South Africa. This trial will enroll 3,000 participants at five sites (Soweto, Cape Town, KOSH, Durban and Pretoria). The HVTN offers circumcision to male participants and provide referral and payment for the procedure. It is anticipated that 20% to 55% of uncircumcised men in these areas would be willing to be circumcised. This group could represent up to 20% of the study population.

Male circumcision has been associated with lower risk of HIV infection only in men. There is a critical and unmet need for prevention strategies that women can initiate and control. The near future will yield data from studies of other prevention strategies that include vaccines, microbicides, cervical barriers, pre-exposure prophylaxis and treatment of HSV-2 infection. Any strategy showing efficacy will have an impact on other prevention strategies and will probably raise identical challenges around resource identification, funding and programmatic implementation.

As various new HIV prevention methods are shown to have efficacy, the HVTN GCAB will help advise the Network on ways to incorporate changes into future HVTN protocols. The AIDS Vaccine Advocacy Coalition has been holding informational calls for CAB members, and you can check their website (see below) for more information on the subject. ☘

Thanks to Mitchell Warren at AVAC for sharing materials accessed at: <http://aidsvaccineclearinghouse.org/MC/index.html>. Thanks to Joe Torres, Lisa Bull, and Sarah Alexander for editorial assistance.

Transitions

We'd like to take a moment to welcome some new site staff. David Garcia joins the Network as the new Community Educator at the Seattle site. We have two South African sites that are coming on board that have been working for some time now to prepare for HVTN 503, the Phambili trial. These are the CAPRISA site from Durban and the Medunsa site from Pretoria.

From our new sites, we welcome Dr. Pierre-Alexandre Bart, who will be leading Lausanne's community education work, educators Gayle Hartis and Elianise Joseph from the Raleigh site, and Paula Frew from Atlanta. We look forward to meeting you all, and working with your CABs!

Beginning on April 23rd, the Community Education Unit will have a new Associate Director. Enid Moore, RN, BSN, MpA, will be taking over where Gaston Djomand, our Interim Director, left off. Coming to us with an extensive background in community education, public health, liaison work as a nurse coordinator, and management responsibilities, Enid is excited to meet CAB members at the upcoming HVTN Conference. We will be having an introductory session with her at the Conference, and you will be hearing more from her in these pages very soon! More than anything, we want to know what she thought about the Boston Marathon, which she ran a few weekends ago. As we make the transition, we give our thanks to Gaston Djomand, who has been a thoughtful advocate and manager for us over the last year.

Joe Torres joined the HVTN after working with the Fred Hutchinson Cancer Research Center Institutional Review Board. Prior to his tenure at FHCRC, he worked for an Insurance Defense Law Firm in San Diego, CA. Joe earned a BA in English Literature from San Diego State University on a full scholarship from the Los Angeles World Affairs Council.

During his undergraduate work, he served on the Associated Student Council and was involved in the campus redesign project. Joe also helped develop student discussion forums to address issues of race, class, gender and sexual orientation to prospective teachers.

When away from the office, Joe loves to travel, cook, and read (mostly works outside the traditional literary canon), and he is currently training for a 205-mile bicycle ride to raise money for a local AIDS service organization. Joe is the proud parent of little Augusten – a one-year-old mini-rex rabbit. Joe speaks fluent Spanish, some French, and is working (slowly) on his Portuguese. ☘



Conferences and announcements

May 18th is HIV Vaccine Awareness Day!

The next HVTN Conference will be held November 1-3, 2007, in Seattle, WA.

This year, AIDS Vaccine 2007 will be held in Seattle, WA. AIDS Vaccine 2007 is a meeting for scientists from all fields



Calendar of events



CAB Scientific Working Group conference call:

Friday, June 1, 8 a.m. PST/11 a.m. EST

Friday, July 6, 8 a.m. PST/11 a.m. EST

Global GCAB conference call:

Thursday, May 10, 8 a.m. PST/11 a.m. EST

Thursday, June 14, 8 a.m. PST/11 a.m. EST

Global Ethics Working Group call:

Thursday, May 24, 9 a.m. PST/12 p.m. EST

Thursday, June 28, 9 a.m. PST/12 p.m. EST

Community Education/Recruitment coordination call:

The Community Educators and Recruiters have decided to move to a model of both global and regional discussions. A new call schedule has yet to be decided.

Community Advisory Boards (CABs) are one way that the HVTN involves community in the research process. CABs consist of volunteers from diverse backgrounds who work with local research units and advise the site from a community perspective. Community input has been invaluable to the broad community education efforts, as well as to the development of this bulletin.

Send suggestions, questions, and article submissions to:
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