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California Stories

California Law Adds New Twist to Abortion, Religious Freedom Debate

Kelly McEvers, NPR, as reported by KQED News | 11.4

The latest front in the debate over religious freedom is all about an 8½-by-11-inch piece of paper.

This particular piece of paper is a notice — one the state of California will soon require to be posted in places known as crisis pregnancy centers. These resource centers, often linked to religious organizations, provide low-cost or free services to pregnant women, while encouraging these women to not have abortions.

The new notice is mandated by the Reproductive FACT Act, and would make it clear that abortion is legally available in California.

But several pregnancy centers are suing the state, asking for the law to be struck down.

One of the clinics engaged in the lawsuit is the East County Pregnancy Care Clinic in El Cajon, Calif., just outside San Diego. The center describes itself as “a religious, nonprofit, pro-life, free medical clinic licensed by the State of California.” It sits on the corner of a busy intersection, surrounded by strip malls.

A big sign out front says “free pregnancy tests.” That’s one way they get women in the door, according to executive director Josh McClure.

McClure is not a physician, though the clinic does have medical advisers who are doctors, he says. When we recently visited, he didn’t permit NPR to talk to the staff at the clinic, who are all either registered nurses or volunteers. But he did offer to show us around, and walk us through the process of what happens to clients who come to the clinic thinking they may be pregnant.

Most of these women make appointments, he says, but the clinic also receives one or two walk-ins a day. The staff sees about 800 women a year, and that number is on the rise.

First, clients fill out paperwork in the lobby, he explains, then are assigned to a volunteer that he describes as an “advocate.”

These volunteer advocates, who are not medical professionals, take the client into a small room called the library. There the volunteer leads the client through a conversation about her situation.

McClure says his volunteer will ask the client a series of questions to get at these issues: “Why do they think they’re pregnant? [Are] they living with somebody? Is it a husband, boyfriend? What are the circumstances going on in their life? And if the pregnancy does happen to be positive, what are they thinking about right then?”

The library has two shelves with books like “What To Expect When You’re Expecting,” anatomy models that show the size of the fetus at four weeks gestation, eight weeks, and so on; and VHS tapes about abortion and abortion providers. McClure says the tapes are from the 1970s and are hardly ever used.

After a client speaks with the advocate and reviews the pamphlets, she is taken to an exam room to take a pregnancy test.

The exam room looks like any medical examining room, with clean linoleum floors, health pamphlets and a box of rubber gloves on the counter. In the center of the room is an exam table with a sheet of white tissue paper laid out over it.

That's where a registered nurse would hand the patient a specimen cup to get a urine sample and do a pregnancy test, McClure says. It's the same test you might buy at a drugstore, he says, but here it's free, funded by donations. The RN signs off on the results.

If the pregnancy test is positive, the nurse tells the client there are three options: parenting, adoption or abortion.

"We're going to talk about the benefits, responsibilities and side effects of all three," McClure says. "We would say, if it's an unplanned pregnancy, there really aren't any good solutions. They're all hard."

In the discussion of parenting, the nurse talks about the responsibility of an 18-year commitment to another human life, and the resources in the client's life that may be helpful. The nurse asks whether the boyfriend or husband would be involved.

In discussing adoption, the clinic goes over several different options: familial adoption to a family member, local or national adoptions and open or closed adoption. McClure says the clinic works with several adoption agencies and will refer clients to the one that best suits her preferences.

"We do let them know, that if there's drug abuse, the reality is if you're not going to straighten your life out by the time the baby is here, that [Child Protective Services] would be coming to take that child," he says.

When it comes to abortion, the nurses do not tell clients where they can get an abortion or refer them to abortion providers, McClure told us. But they will talk about the clinic's view of the risks of an abortion and the cost.

"Generally," McClure says, "the further along you go, the more expensive and more invasive and more risks there are. Risk of sterility is one. Perforated uterus is another. And then, of course, emotional side effects as well. All the information we're giving about the side effects is backed by research and referenced."

McClure didn't mention during our tour that at least some claims in that pamphlet used to train the clinic's nurses and volunteers are disputed by leading research organizations. For example, the suggestion that there might be a link between abortion and an increased risk of breast cancer has been studied and eventually dismissed by the National Cancer Institute and other medical groups.

The clinic's pamphlet also states that abortion "significantly increases the risk" for conditions such as "clinical depression and anxiety" and "suicidal thoughts and behavior." But an American Psychological Association task force on mental health and abortion had a different take in its recent review, recognizing that "abortion encompasses a diversity of experiences."

According to the APA's task force report in 2008, "the best scientific evidence published indicates that, among adult women who have an unplanned pregnancy, the relative risk of mental health problems is no greater if they have a single, elective first-trimester abortion than if they deliver that pregnancy. The evidence regarding the relative mental health risks associated with multiple abortions is more equivocal."

Once a pregnant woman at McClure's clinic has been briefed by the staff on how their organization views the risks of abortion, she is brought to a room where she can get an ultrasound scan, free of cost.

There, McClure tells us, the ultrasound image is enlarged and projected onto a big flat-screen TV. Women often decide against abortion, he says, after they see the ultrasound.

"When you have an image on a screen, all the cloudiness of what we're talking about kind of goes away," McClure says. "They're able to see for themselves: OK, arms, legs, eyes, head. Bingo — that's a baby."

The last stop is a closet full of diapers, wipes, baby clothes, blankets and maternity clothes — all available for free to clients who have trouble affording those things.

That's the end of the tour.

None of these things — no step in that process — would have to change under the Reproductive FACT Act.

Instead, the law requires centers like the East County Pregnancy Care Clinic to post a sign in the lobby that says, in 22-point type:

California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].

If the center is not a licensed medical clinic, the sign would state:

This facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services.

McClure says a sign in the lobby is not how or when he wants his clients at the clinic to hear about abortion. It goes against everything his center stands for, he tells NPR.

One of the people responsible for the law requiring this new sign is Autumn Burke, who represents Inglewood in the California Assembly.

Burke tells NPR that her interest in the issue started the day she went to get her phone fixed at a shop near a clinic that performs abortions. Protesters outside the clinic gave her pamphlets, she says, making claims that she knew weren't true.

“It [said] that abortion causes breast cancer,” Burke recalls, “that if you are on birth control boys will not like you, or they will take advantage of you.”

A few days later, one of Burke’s colleagues in the California Assembly asked her to co-sponsor the Reproductive FACT Act.

“And I thought, ‘You know what? This is timely,’ ” Burke says. “Making sure women have the correct information.”

A number of health and medical groups, including the regional district of the American Congress of Obstetricians and Gynecologists, the California Nurses Association and the Primary Care Association, also supported the legislation.

Burke acknowledges that some crisis pregnancy centers do give good help to women who want to have babies. But she says that others give false information to women or pose as clinics, even though they don’t have a medical license.

Burke says the law is for those bad actors, and that putting up this sign in these centers wouldn’t be much different than a notice from the health department or the building inspector.

“It’s like a ‘Wash Your Hands’ sign on the wall,” says Burke.

Brad Dacus of the Pacific Justice Institute, one of the groups suing the state of California over the new law, could not disagree more.

“It’s like telling the Alcoholics Anonymous group that they have to have a large sign saying where people can get alcohol and booze for free,” Dacus says. “It’s like telling a Jewish synagogue that they can have their service, and do their thing, but they have to have a large sign where people can go to pray to receive Jesus.”

Dacus’s organization has filed a challenge to the law in federal court.

Some U.S. cities, including Austin, Texas, Baltimore and San Francisco, have passed similar legislation and have faced similar legal challenges — with mixed results.

The state of California so far is the largest jurisdiction in the country to pass a law requiring these centers to inform women about the availability of abortion services. If the law holds up, it could make way for measures like it in other cities and states.

Brad Dacus says that if the case has to go all the way to the Supreme Court to stop the law, so be it. To him, the legal battle is all about upholding the right to religious freedom.

“If people are not allowed to carry out their faith, and act and actually exercise their faith — not just have their private beliefs, but actually exercise their faith — then we really don’t have religious freedom,” Dacus says.

The lawsuits against the Reproductive FACT Act are now making their way through the courts.

Kristin Ford, representing the office of California Attorney General Kamala Harris, says, “We will vigorously defend the state law in court.”

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

OPINION: Condom law might force p*rn producers to decamp from California

David Horsey, Los Angeles Times | 11.9

Can condoms cause the hugely profitable California p*rn business to go limp? In November 2016, state voters may be asked to pass judgment on a ballot initiative that would require actors in adult films to wear condoms when they engage in onscreen sex acts. Supporters of the initiative say it will protect thrusting thespians from contracting diseases. P*rn producers insist condoms would be a total buzz kill.

P*rnographic filmmakers warn that, if the initiative becomes law, they will pack up their cameras, lights, high heels, hair removers, handcuffs, vibrators, lubricants, strap-ons and other exotic paraphernalia and leave California. On the plus side, that means residents from the San Fernando Valley to Ventura will be assured that the high-pitched yowling from the house next door is coming from a distressed cat, not from a p*rn actress in mid-performance. On the negative side, state and local tax revenue could drop by tens of millions of dollars.

Since the passage of a countywide condom mandate in 2012, Los Angeles County has seen a 90% decline in applications for filming permits from p*rn producers, so the threat of a revenue slump is real. Still, would dirty-picture impresarios and their merry troops of naked performers really decamp for Oregon or Arizona and leave the glitz of L.A. just because of condoms? Is this about art, health or money?

The p*rnography industry is layered, very much like Dante’s nine circles of Hell. The deeper you go, the darker and more perverse it becomes (and the more everyone seems to have an Eastern European accent). In the upper circles, though, the inherent abuse and misogyny of the business is much less overt. There is a low-rent glamour and lure of quick celebrity in the higher-level p*rn world that mimics the legitimate film industry. There are awards ceremonies, there are branding opportunities, and there are the thrills of signing autographs at car shows. Filming goes on in pleasant suburban neighborhoods, by sunlit swimming pools and in the bedrooms, bathrooms and kitchens of upscale Spanish colonial homes.

The young women who perform in California-made p*rn do not seem blessed with great intellect or formidable acting skills, but they exhibit boundless enthusiasm for their work. It may be naive to say this, but the most surprising thing about the women in p*rn is how many of them there are — a seemingly endless stream of pretty twentysomething females coming to L.A. from all parts of the country with a willingness to strip off their clothes and do just about anything in front of a camera, no matter how acrobatic, ridiculous or challenging to the elasticity of human flesh.

These young women are the focal point of p*rn. They get all the screen time. The men in the movies almost do not count. Their faces are rarely shown, which is probably a good thing since a lot of p*rn performers look as if they are on work release from state prison. There is really only one reason the men are even there, only one thing they contribute to the artistic enterprise. And that one thing is usually inordinately large.

It is no wonder p*rn producers are upset about being forced to cloak that one thing with a prophylactic sheathe. It is as troubling for them as it would be if a regular Hollywood filmmaker were told his lead actor were required to put a bag over his head. Imagine Daniel Craig running through his paces as James Bond while blinded by a Whole Foods sack. It wouldn't be what the audience paid to see.

Condoms are not what the p*rn audience pays to see, either, and the p*rn producers know it. If they have to leave California to keep their profits high, they just might do it. And that means there is a big economic opportunity waiting for a more libertarian state. Texas? Wyoming? Oklahoma? Are you ready to be the new p*rn capital of the world?

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

National Stories

Congenital syphilis rates increase across US

Dave Muoio, Healio Infectious Disease News | 11.12

The incidence of congenital syphilis in the United States increased 38% between 2012 and 2014, with last year's overall case rate the highest recorded since 2001, according to recently published CDC surveillance data.

This increase mirrors — and may be driven by — similar increases in syphilis infection rates among women over this same time period, according to Virginia Bowen, PhD, MHS, officer of the CDC's Epidemic Intelligence Service, and colleagues.

“The findings from this report show we are missing opportunities to screen and treat pregnant women for STDs,” Bowen told Infectious Disease News. “Syphilis in pregnant women can cause miscarriages, premature births, stillbirths, or death of newborn babies. We have great tests and effective treatment for syphilis — there's no excuse for allowing it to resurge, especially among pregnant women who are largely engaged in medical care.”

A reversal of positive trends

Previous surveillance data showed a decrease in congenital syphilis cases from 1991 to 2005, but more recently a minor increase from 2005 to 2008. To document more recent incidence rates and identify transmission trends, Bowen and colleagues examined CDC surveillance data collected through the National Notifiable Diseases Surveillance System from 2008 to 2014. Included cases of congenital syphilis included stillbirths, infants with clinical evidence of the disease, and all stillbirths and infants born to mothers with undertreated syphilis. Incidence rates were calculated per 100,000 live births as determined by data from the National Center for Health Statistics. Rates of primary and secondary (P&S) syphilis per 100,000 women obtained using U.S. Census population estimates also were collected for analysis, and demographic and clinical features of the infants and mothers were analyzed to identify trends in transmission.

From 2008 to 2012, the researchers observed a decline in congenital syphilis cases from 10.5 cases per 100,000 live births to 8.4 cases per 100,000 live births. This decline was seen within all regions of the U.S. except the Midwest, which reported a rate increase of 62%. Case rate decreases during this period were greater among whites than blacks, and the majority (57%) of congenital syphilis cases in 2012 were among infants with black mothers.

These overall positive trends were reversed from 2012 to 2014, as the congenital syphilis rate increased to 11.6 cases per 100,000 live births. This change was seen throughout the U.S., but was greatest in the West (5.5 cases per 100,000 live births vs. 12.8 cases per 100,000 live births). Incidence increases were seen among whites (61%), Hispanics (39%) and blacks (19%), although infants of black mothers remained the most affected in 2014.

There was a slight rise in the proportion of congenital syphilis cases that resulted in stillbirth or early infant death throughout the study period. Stillbirths accounted 5.4% of reported cases in 2008 and 5.5% in 2014, while reports of infant deaths within 30 days increased from 0.7% to 1.7% during the same time period. In 2014, 6.5% of reported cases had one or more clinical signs or symptoms of congenital syphilis infection, 11.4% other nonclinical evidence and 9.8% of cases had no treatment recorded at the time of reporting.

The importance of prenatal care

The trends in congenital syphilis identified by the researchers mirrored similar fluctuations observed among U.S. women. From 2008 to 2012, P&S syphilis decreased from 1.5 cases per 100,000 women to 0.9 cases per 100,000, and increased to 1.1 cases per 100,000 in 2014.

According to the researchers, the increase from 2012 to 2014 represents a “missed opportunity” to interrupt the transmission of the infection and is accompanied by low engagement with various areas of prenatal care.

“Notable increases of P&S syphilis among women can create a higher likelihood of increases in congenital syphilis,” Bowen said. “Prenatal care is essential to the overall health and wellness of mother and child — and late or inadequate care is a leading cause of congenital syphilis.”

The researchers found that more than one-fifth of mothers whose children were infected with congenital syphilis in 2014 received no prenatal care, and no information about care was available for 9.6%. Among those who attended one or more prenatal visits, 43% received no treatment for their syphilis infection throughout the pregnancy, and 30% received inadequate treatment. Further, 21 of the mothers who received prenatal care were never tested for syphilis, and 52 mothers acquired the infection after a negative screening early in the course of their pregnancy.

“A substantial percentage of [congenital syphilis] cases are attributable to a lack of prenatal care; even among those receiving some prenatal care, the detection and treatment of maternal syphilis often occurs too late to prevent [congenital syphilis],” they wrote. “Health departments, in partnership with prenatal care providers and other local organizations, should work together to address barriers to obtaining early and adequate prenatal care for the majority of vulnerable pregnant women.”

Along with improving testing and access to care among women of reproductive age and men who have sex with women, other areas of congenital syphilis prevention in need of increased attention include

timely administration of antibiotic treatment, provision of STD partner services and accurate reporting of identified cases, the researchers concluded.

Journal Reference:

[Bowen V, et al. *MMWR*. 2015;64:1241-1245.](#)

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

New single-tablet HIV treatment wins FDA approval

Catharine Paddock, Medical News Today | 11.6

The US Food and Drug Administration have approved a new single tablet as a complete treatment for the treatment of HIV-1 infection in people aged 12 years and over.

The new treatment, called Genvoya, from Gilead Sciences, is a fixed-dose combination of elvitegravir, cobicistat, emtricitabine and tenofovir alafenamide.

It is intended for patients aged 12 and over, weighing at least 35 kg (77 lbs) and who have never been treated for HIV before, or for infected adults whose HIV is currently suppressed.

The drug was tested against other HIV treatments approved by the Food and Drug Administration (FDA) in four clinical trials involving a total of 3,171 participants. Results showed that it reduced viral loads and was comparable to other treatments.

Genvoya contains a new version of tenofovir - a powerful HIV inhibitor - that has not been approved before. Gilead say that because the new version (called TAF) enters cells - including HIV-infected cells - more efficiently than the previous version (TDF), it can be given at a lower dose that results in 91% less tenofovir in the bloodstream.

The new drug was developed to reduce side effects, and the trial results show it appears to be associated with less kidney toxicity and reductions in bone density than previously approved drugs containing tenofovir.

Suitable for patients with moderate kidney impairment

The FDA note that while Genvoya is not recommended for patients with severe kidney impairment, those with moderate impairment can take Genvoya.

However, the US regulator also comments that "patients receiving Genvoya experienced greater increases in serum lipids (total cholesterol and low-density lipoprotein) than patients receiving other treatment regimens in the studies."

The drug's Boxed Warning says it can cause lactic acid to build up in the blood and lead to severe liver problems, both of which can be fatal.

The most common side effect is nausea, and serious side effects include new or worsening kidney problems, reduced bone mineral density, fat redistribution and changes in the immune system.

The warning also says Genvoya should not be given with other antiretroviral drugs and may interact with a number of commonly used medications.

Dr. Edward Cox, director of antimicrobial products in the Center for Drug Evaluation and Research at the FDA, said on Thursday:

"Today's approval of a fixed-dose combination containing a new form of tenofovir provides another effective, once daily complete regimen for patients with HIV-1 infection."

Estimates suggest around 1.2 million Americans aged 13 and over know they have HIV, and more than 150,000 others are infected but do not know it. In the last 10 years, the annual number of new HIV infections has remained relatively stable.

HIV-1 is the predominant strain of HIV that causes the vast majority of HIV infections worldwide. When people refer to HIV, they usually mean HIV-1.

Earlier this year, Medical News Today reported on a study that suggests drugs already being tested for the treatment of cancer could reawaken dormant HIV in cells of patients treated with antiretroviral drugs to allow complete eradication of the virus.

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

Good Talks Needed to Combat HPV Vaccine Myth

Aaron E. Carroll, The Upshot, The New York Times | 11.9

When people hear about vaccine deniers — anti-vaxxers, to some — they most often think about parents who are refusing to vaccinate their children. But there's another type of vaccine refusal, and it's important that we not ignore that. Doctors sometimes promote the use of some vaccines with less enthusiasm than others. Sometimes, they don't talk about them at all.

This occurs most often with the human papillomavirus, or HPV, vaccine. The low immunization rates with this vaccine, and the behaviors of the physicians who might be contributing to that, have consequences.

HPV is a sexually transmitted infection that is very, very common, so much so that almost all sexually active people will get at least one of more than 40 types at some point in their lives. The C.D.C. estimates that almost 80 million Americans are currently infected with HPV, and that about 14 million people will become newly infected this year.

Most people don't suffer any real negative health consequences. But some do. About 1 percent of those infected will have genital warts at any given moment. More important, about 17,500 women and 9,300 men will be affected by cancers that HPV causes each year. These include cervical, oropharyngeal, anal, vaginal and penile cancers.

This is preventable. The C.D.C. recommends that all children, boys and girls, begin receiving the first of three vaccinations when they are 11 or 12 years old. The reason we start that young is that it's

important that children be immune well before they become sexually active. Once they are exposed to the virus through sexual activity, the vaccine may be less effective.

Let's also be clear. Regardless of what some presidential candidates say, the vaccine is safe. The scary emails and Internet horror stories you might have read can easily be explained away. The vaccine works, and it's not dangerous.

Our immunization rates for HPV fall far short of other vaccine rates. Last year, less than 42 percent of those ages 13 to 17 received at least one dose of the HPV vaccine. Fewer receive all three shots.

Even this rate of vaccination has made a difference, though. A study published two years ago in *The Journal of Infectious Diseases* examined the prevalence of HPV infections in girls and women both before and after the vaccine was introduced. Among those 14 to 19, the prevalence of HPV decreased from 11.5 percent before 2006 to 5.1 percent after. This drop could not be accounted for by changes in demographics or sexual activity.

The remarkable reduction in HPV prevalence occurs even though only about a third of girls 13 to 17 received all three doses of the vaccine in 2010. The C.D.C. director, Tom Frieden, estimated then that if we could increase the vaccination rate to 80 percent, far lower than we see with most other vaccines, we could prevent 50,000 cases of cervical cancer in women. He argued that every year we did not achieve this goal would result in an additional 4,400 women getting cervical cancer at some point in their lives.

Policy is partly to blame here. Although states pretty much mandate all childhood vaccines as necessary for entry into school, fewer focus on diseases affecting adolescents. However, all states and the District of Columbia require immunity to chickenpox; 47 states and D.C. require vaccination against hepatitis B; and 29 states and D.C. require it for meningococcus.

Only two states, Rhode Island and Virginia, and the District of Columbia require vaccination against HPV.

Parental and adolescent beliefs certainly come into play. Myths about the safety of the HPV vaccine persist despite overwhelming evidence that the immunization is safe.

Doctors bear responsibility here as well. A recent study by Melissa Gilkey, a behavioral scientist at Harvard Medical School, surveyed pediatricians and family physicians to examine their communication practices around vaccines. She found that more than a quarter of doctors didn't endorse the vaccine strongly. About a quarter did not make timely recommendations for girls, and almost 40 percent didn't make timely recommendations for boys. Only half recommended same-day vaccinations, and almost 60 percent used a risk-based approach, recommending the vaccine more often to patients they thought were at higher risk of HPV infection, such as those more likely to be sexually active.

This is, of course, a problem. If a child is already sexually active, it may be too late to protect them.

Ms. Gilkey's prior work found that physicians felt that talking to patients about the HPV vaccine took significantly more time than for other vaccines, which may make them less likely to engage. Further, some physicians believe many parents don't think HPV vaccination is important for their 11- and 12-year-olds. While three-quarters of doctors reported perceiving parental support for the Tdap vaccine, for instance, only 13 percent believed parents supported the HPV vaccine.

That's not the case. A study published last year in the journal *Vaccine* found that doctors underestimated how important vaccines were to parents and overestimated parental concerns about how many shots their children were getting. Other research shows that the most common reason for adolescents not to receive the HPV vaccine isn't parental refusal; it's a lack of physician recommendation.

Even if there are parental concerns, it's up to the physician to address them. One of the nation's pre-eminent experts in HPV vaccine behavioral research, Greg Zimet, has an office downstairs from me at Indiana University School of Medicine. His research has also found physician communication to be a significant predictor of HPV coverage.

A point that Mr. Zimet has made repeatedly, however, is that the number of behavioral studies of the HPV vaccine is far, far greater than for any other vaccine. There's something about this vaccine that causes people to behave differently when discussing, considering and administering it.

The elephant in the room is, of course, sex. This vaccine prevents a sexually transmitted infection, and there is a pervasive belief that when parents, or even doctors, give the vaccine, they may be condoning sexual activity in young adolescents.

This is, of course, not true. Many engage in sexual activity with or without the vaccine. We administer the immunization to protect them regardless. Moreover, research is abundant in this domain. A 2012 study published in *JAMA Pediatrics* found that girls perceived no less need for safer sexual behaviors after getting the HPV vaccine. A 2014 cohort study of more than 260,000 girls found that those who received the HPV vaccine were no more likely to get pregnant or to contract a non-HPV-related sexually transmitted infection than girls who were unvaccinated. This confirmed findings from a smaller cohort study from 2012.

The good news is that this is all fixable. Research consistently shows that doctors have a lot of influence on parents' decision making about HPV vaccination. They should just talk about it as they do with all other vaccinations in a straightforward, unambiguous way. As Ms. Gilkey told me, "Just by letting parents know that HPV vaccination is very important for all 11- and 12-year-olds, physicians and other vaccine providers can do a lot to overcome the barriers that have kept coverage low in the U.S."

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

Bristol-Myers Squibb's HIV Maturation Inhibitor Shows Promise

As reported by aidsmeds.com | 10.27

Research of Bristol-Myers Squibb's BMS-955176, an HIV maturation inhibitor, has shown the antiretroviral is potent and well-tolerated, findings that support further research. Researchers presented findings from the three-part, randomized Phase IIa proof-of-concept study of the drug at the 15th European AIDS Conference in Barcelona.

The study included people with HIV-1 who had a viral load of at least 5,000 and a CD4 count of 200 or greater.

Part A of the study initially included 40 people with subtype B of the virus. They were randomized into five groups of eight people, who received either 5 milligrams, 10 mg, 20 mg or 40 mg of BMS-955176, or took a placebo. Later, an additional 20 people joined the trial, with two groups of eight people receiving 80 mg and 120 mg of BMS-955176, respectively, while an additional four people joined the placebo group.

After 10 days of treatment, the median viral load drop ranged from 0.15 powers of 10 in the 5 mg group to 1.35 and 1.36 powers of 10 in the 80 mg and 120 mg groups, respectively, while those who took the placebo experienced a median viral load drop of 0.03 powers of 10. (One power of 10 is equivalent to a 90 percent reduction and two powers of 10 to a 99 percent reduction.) After 24 days of treatment, the median viral load drop ranged between 0.5 powers of 10 in the 5 mg group to 1.70, 1.56, and 1.65 powers of 10 in the 40 mg, 80 mg and 120 mg groups, respectively; while those who took the placebo experienced a median viral load drop of 0.38 powers of 10.

Part B of the study included 28 people with subtype B of HIV. They were randomized so that there were eight people in three groups and four people in a control group. Respectively, those groups took 40 mg of BMS-955176 and 400 mg of Reyataz (atazanavir); 40 mg of BMS-955176, 300 mg of Reyataz, and 100 mg of Norvir (ritonavir); 80 mg of BMS-955176 and 400 mg of Reyataz; and 500 mg of Truvada (tenofovir/emtricitabine), 300 mg of Reyataz, and 100 mg of Norvir.

After 28 days of treatment, the median drop in HIV viral load was a respective 1.66, 1.99 and 2.18 powers of 10 in the three groups of eight people, compared with 2.22 powers of 10 in the control group. After 42 days of treatment, the median drop in viral load was a respective 1.86, 2.2 and 2.23 powers of 10 in the three groups of eight people, compared with 2.39 powers of 10 in the control group.

Part C of the study included 19 participants with subtype C of the virus. They were randomized so that eight people took 40 mg of BMS-955176, seven took 120 mg of the drug, and four people took a placebo.

After 11 days of treatment, the median viral load drop was 1.21 powers of 10 in the 40 mg group and 1.03 powers of 10 in the 120 mg group, while the placebo group saw a median viral load increase of 0.001 powers of 10. After 24 days of treatment, the median viral load drop was 1.35 powers of 10 in the 40 mg group, 1.26 powers of 10 in the 120 mg group, and 0.42 in the placebo group.

BMS-955176 proved safe and well tolerated in all three parts of the study.

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

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

With EACS release, all international HIV treatment guidelines agree on when to start – for the first time since 2006

Gus Cairns, aidsmap.com | 10.26

Treatment for all on diagnosis now recommended

The new European AIDS Clinical Society (EACS) HIV clinical guidelines, released last week at the 15th European AIDS Conference, bring Europe into line with the rest of the world by recommending HIV treatment upon diagnosis for all patients.

This is the first time since 2006 that all internationally-written guidelines have agreed on their 'when to start' recommendations. As a measure of what has changed since then, in that year the guidelines by EACS, the World Health Organization (WHO), the US Department of Health and Human Services (DHHS), the International AIDS Society USA (IAS-USA) and the British HIV Association all agreed that treatment was only strongly recommended for people with CD4 counts below 200 cells/mm³. They did not recommend treatment for people with CD4 counts over 350 cells/mm³, and recommended it only with caution for people with CD4 counts between 200 and 350 cells/mm³. Now, in line with all other guidelines, EACS recommends that treatment is offered to all people diagnosed with HIV, though they still reserve a category of "strong recommendation" for people diagnosed with CD4 counts below 350 cells/mm³.

"When to start was the easiest part to write", commented Dr José Gatell, the Conference co-chair, referring to the START study, which showed that treatment is beneficial at all CD4 counts.

What to start with

The guidelines show much less harmony when it comes to what to start with, however. This partly reflects very new information this year about the effectiveness of the integrase inhibitor drugs raltegravir and dolutegravir, and also partly reflects whether guidelines are primarily intended to apply to patients in low- or high-income countries.

In terms of what is still called the 'backbone' of two nucleoside reverse-transcriptase inhibitor (NRTI) drugs, the international guidelines are reasonably in agreement, recommending tenofovir and emtricitabine (Truvada) unanimously. Abacavir and lamivudine (Kivexa/Epzicom) are recommended as an equal first choice by EACS, DHHS and IAS-USA, but recommended only as an alternative choice by BHIVA (largely due to questions over its potency in people with high viral loads). WHO does not recommend abacavir/lamivudine since many lower-income countries lack the ability to test people beforehand for the B*5701 genetic variation in their immune system that indicates likely hypersensitivity to abacavir.

There is less agreement over the third agent, however. The biggest disparity in views is over the drug efavirenz (Sustiva/Stocrin, also in Atripla). This former mainstay of HIV treatment, which has been in the drug arsenal since 1998, is still recommended by the WHO as their one preferred third agent for first-line HIV treatment, either as a component of Atripla or alongside tenofovir and emtricitabine, Atripla's other components. This partly reflects the fact that the WHO decided not to change its recommendations on what to start with when it changed its recommendation on when to start this year.

In contrast the DHHS guidelines, also revised this year, do not include any of the non-nucleoside (NNRTI) drugs, of which efavirenz is one, in their five recommended first-line regimens. Instead they recommend only regimens based on the integrase inhibitor drugs and on one remaining protease inhibitor, darunavir.

As a measure of how fast things have changed, the IAS-USA guidelines, released only last year, were still recommending regimens based on efavirenz and on two other NNRTIs, etravirine and rilpivirine, in its eleven recommended starting regimens, and also the protease inhibitor atazanavir, which is not even recommended as an alternative by the DHHS (or by the WHO, which recommends no protease inhibitors, partly due to their larger cost).

EACS compromises between the DHHS and IAS-USA positions. They recommend six first-line regimens. Four use integrase inhibitors as their third drug (Truvada plus dolutegravir, Truvada plus raltegravir, the combination pill Triumeq (which is Kivexa plus dolutegravir), and the combination pill Stribild (which is Truvada plus boosted elvitegravir). They also recommend the NNRTI-based Complera/Eviplera pill, which is Truvada plus rilpivirine, and the PI-based Truvada-plus-ritonavir-boosted darunavir.

In a panel discussion during a session presenting the new EACS guidelines, Marco Vitoria of the WHO writing group defended the retention of efavirenz.

He said: “Even though with efavirenz there is an increased relative risk of side effects, the absolute risk remains small and dolutegravir” (which is the first non-boosted, once-daily integrase inhibitor) “will not be available as a generic drug for at least two years.”

EACS treasurer Nathan Clumeck questioned WHO’s decision to have, as its only recommended regimen, one that has a low genetic barrier to resistance (resistance to efavirenz arises very quickly in conditions of partial adherence).

Stefano Vella, answering for WHO said: “We did consider a PI-based regimen as first-line therapy but ruled them all out owing to cost, practicality and side effects. We have been using efavirenz in low-income countries for years with good effects on mortality.”

José Gatell said that this was the reason EACS has decided to retain one NNRTI-based regimen. The integrase inhibitors were still relatively new and dolutegravir had only recently been licensed: in contrast “NNRTIs are used all over the world”, he said, and the EACS guidelines are also used on lower-income countries.

PrEP and PEP

Other changes in the new guidelines include a positive recommendation for pre-exposure prophylaxis (PrEP), which brings them into line with the US, WHO and BHIVA. PrEP is “recommended” for “men who have sex with men and transgender individuals, who are inconsistent in their use of condoms with casual partners or with HIV-positive partners who are not on treatment,” and “may be considered” for “heterosexual men and women who are inconsistent in their use of condoms and are likely to have HIV-positive partners who are not on treatment.”

The guidelines emphasise that PrEP is a medical intervention that may have side effects, does not protect against other STIs, “may not provide full protection against acquiring HIV” and should be prescribed and supervised by a doctor experienced in sexual health.

The guidelines recommend that PrEP can be prescribed as a daily or intermittent regimen, in the latter case taken as it was in the Ipergay study (a double dose in the 24 hours before sex then one dose each on the two following days after sex).

EACS have also changed their recommendations for post-exposure prophylaxis (PEP). They no longer recommend PEP if the source partner is HIV-positive with an undetectable viral load, a change that finally brings them into line with BHIVA, and they recommend Truvada plus darunavir/r or raltegravir as regimens.

Hepatitis C co-infection

The hepatitis C (HCV) recommendations now exclude the use of pegylated interferon and ribavirin as first choice (though, recognising that some countries are still using them, dosing advice for interferon/ribavirin regimens is included in the appendix pages that are only available online rather than in the printed guidelines).

The recommendations include six direct-acting antiviral (DAA) regimens for hepatitis genotype 1, 4 and 6, three for genotype 3, two for genotype 2 and one for genotype 5. This is because some drugs only work for certain genotypes.

Co-morbidities and ageing

Another change is not so much in specific recommendations as emphasis. The section on the Prevention and Treatment of Co-morbidities in people with HIV now includes a specific statement: "We recommend multi-disciplinary care for aging HIV patients with multiple co-morbidities and chronic immune activation to preserve good quality of life and prevent frailty."

Georg Behrens, who co-ordinated the co-morbidity section, said that this section – which includes recommendations for dealing with everything from cancer to depression – is the one that has most expanded since the last guidelines, necessitating removing a number of sections to the web-only version of the guidelines. The challenge in writing guidelines for co-morbidities, he said was deciding what to leave out: "If you tested for every co-morbidity that can be raised in people with HIV, patients would never leave the clinic."

This is because as the HIV-positive population ages, it is becoming clearer that certain conditions that arise with age can be more frequent or more severe in people with HIV. More "aggressive" monitoring of kidney function is recommended in people with an even slightly depressed glomerular filtration rate (GFR) and progressive decline, and much more use of depression screening is recommended.

Practicality and affordability

Some people in the audiences commented on the practicality of some recommendations – integrase-inhibitor-based regimens, PrEP, HCV DAAs – in eastern Europe. Jürgen Rockstroh, who co-ordinated the co-infection guidelines, commented that huge and illogical disparities in drug prices were also partly to blame, citing the contrast between Germany, which paid high prices for HCV DAAs, and Portugal, which had managed to negotiate much lower ones.

Guidelines chair Jens Lundgren said he always encouraged his students to work at placements in eastern Europe – "it reminds me of what things used to be like here, you still see people dying of AIDS." He urged that EACS do more to liaise with eastern European doctors and support their fight for better treatments for their patients.

Reference:

European AIDS Clinical Society. *European Guidelines for treatment of HIV-infected adults in Europe, version 8.0*. 2015. See <http://www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html>

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

Viread Gel Linked to Lowered Risk of Herpes Among Women

As reported by aidsmeds.com | 11.11

Women who regularly used a Viread (tenofovir)-based vaginal gel had a 46 percent reduced risk of acquiring herpes simplex virus type 2 (HSV-2), according to a secondary analysis of the VOICE trial, aidsmap reports. Researchers presented their findings at the HIV Research for Prevention conference in Cape Town, South Africa.

The VOICE trial was a Phase IIb, randomized, double-blind study testing the safety and efficacy of daily oral Truvada (tenofovir/emtricitabine) as pre-exposure prophylaxis (PrEP) against HIV as well as a vaginal microbicide gel containing 1 percent Viread as PrEP. Overall adherence was very low, with less than 25 percent of the women demonstrating evidence of having used the gel.

Among the women who did not use the gel, the rate of HSV-2 acquisition was 20.1 percent, compared with 11.5 percent among those who used the gel regularly. There was no significant difference in the rate of new HSV-2 cases between those who were given a placebo gel and those who were assigned to take the Viread-containing gel but who had no detectable drug: The respective rates were 17 percent and 19.2 percent.

More research is still needed to determine the relation between using Viread and the likelihood of acquiring HSV-2.

To read the aidsmap story, [click here](#).

To see a PowerPoint presentation on this study, which includes an audio of the presentation, [click here](#).

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

Two Hepatitis C Drugs Can Cause Liver Injury, FDA Warns

AbbVie will add indications to Technivie and Viekira Pak warning against use in moderate to advanced cases

Daniela Semodo, Hepatitis News Today | 11.5

Federal health officials are cautioning patients and clinicians about the potential for life-threatening liver injury in two AbbVie drugs used for the treatment of advanced forms of hepatitis C.

The Food and Drug Administration (FDA) announced on Oct. 22, 2015, that AbbVie will need to add new indications to Technivie and Viekira Pak after reported liver transplants and deaths of patients who previously had liver injury caused by the hepatitis C virus. This new indications could restructure the

emergent field of high-priced medications for hepatitis C, which also comprises Gilead Sciences' best-selling drugs Harvoni and Sovaldi, according to a news release.

Brian Abrahams, a Jefferies analyst, mentioned in an investment note that the caution is of a "moderate positive" level for Gilead Sciences, and would further challenge AbbVie's Viekira Pak, already under pressure because of a similar drug from Merck & Co. that is expected to be approved in 2016.

Tim Anderson, an analyst at Bernstein, also noted that's AbbVie's hepatitis C medication requires four to six pills each day, as opposed to the once-daily regiment for Gilead's Harvoni as well as Merck's awaited medication. "In the ultra-competitive hep C market, this is likely a damaging event," Anderson wrote in an investment note.

Approximately 3 million people in the U.S. have hepatitis C, a slow progression virus that, if left untreated, can lead to liver cancer and liver failure. In an online post, the FDA noted that AbbVie's drugs have been associated with multiple cases of liver damage, some of which led to death, in hepatitis C patients already with liver cirrhosis or permanent scarring of the liver. The agency determined that 26 of these events were likely results of the medications, with liver damage occurring within four weeks of treatment initiation.

AbbVie stated that a warning will be added to the medications noting they must not be used in patients with moderate to severe liver damage. "Patient safety is of the utmost concern to AbbVie," the company stated.

AbbVie's medications belong to a new group of pill-only combined treatments shown to be more effective in treating hepatitis C and generally cause fewer side effects than previous medications, given by injection and known to cause flu-like symptoms. Viekira Pak treats the most common hepatitis C type (genotype 1), accounting for nearly 75% of all hepatitis C cases in the United States. Technivie, approved in July, was developed to treat one of the least common forms of hepatitis C.

Gilead Sciences initially controlled the market, reporting \$9.4 billion in sales for its Sovaldi medication during its first year on the market. The drug was approved by the FDA in December 2013. Gilead followed that approval with the introduction of Harvoni, a combination pill for the treatment of a broader group of patients with hepatitis C.

While patients and clinicians have embraced the new medications, insurers are troubled by their high prices — about \$83,000 for one treatment course. The introduction of AbbVie's Viekira Pak was embraced as a much-needed competitor in the field.

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

Scientific Papers/Conference Abstracts

Increase in Incidence of Congenital Syphilis — United States, 2012–2014

Bowen V, Su J, Torrone E, et al. *MMWR* 2015;64(44):1241-1245

Congenital syphilis (CS) occurs when a mother infected with syphilis transmits the infection to her child during pregnancy. CS can cause severe illness, miscarriage, stillbirth, and early infant death. However, among pregnant women with syphilis who deliver after 20 weeks gestation, maternal treatment with penicillin is 98% effective at preventing CS (1). In the United States, the rate of CS decreased during 1991–2005 but increased slightly during 2005–2008 (2). To assess recent trends in CS, CDC analyzed national surveillance data reported during 2008–2014, calculated rates, and described selected characteristics of infants with CS and their mothers. The overall rate of reported CS decreased from 10.5 to 8.4 cases per 100,000 live births during 2008–2012, and then increased to 11.6 cases per 100,000 live births in 2014, the highest CS rate reported since 2001. From 2012 to 2014, reported cases and rates of CS increased across all regions of the United States. To reduce CS, the timely identification of and response to increases in syphilis among women of reproductive age and men who have sex with women are essential. All women should have access to quality prenatal care, including syphilis screening and adequate treatment, during pregnancy (3).

CS is a nationally notifiable disease with case data reported to CDC by all 50 states and the District of Columbia through the National Notifiable Diseases Surveillance System.* For surveillance purposes, the definition of a CS case includes both stillbirths and infants with clinical evidence of CS, as well as stillbirths and infants born to mothers with untreated or inadequately treated syphilis, regardless of the infant's manifestation of clinical disease. CDC analyzed cases of CS reported during 2008–2014, describing selected demographic and clinical features of infants with CS and their mothers. CS rates were calculated as cases per 100,000 live births by using U.S. natality data published by the National Center for Health Statistics (4). Rates of primary and secondary (P&S) syphilis, a measure that combines two stages of recently acquired infectious syphilis to monitor incident disease, were calculated among women as cases per 100,000 women by using U.S. Census population estimates (5). Because 2014 natality and Census data were not yet available, CS and P&S rates for 2014 were calculated by using 2013 denominators.

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

HIV Testing, HIV Positivity, and Linkage and Referral Services in Correctional Facilities in the United States, 2009–2013

Seth P, Figueroa A, Wang G, et al. *Sex Transm Dis* 2015;42(11):643-649

Background:

Because of health disparities, incarcerated persons are at higher risk for multiple health issues, including HIV. Correctional facilities have an opportunity to provide HIV services to an underserved population. This article describes Centers for Disease Control and Prevention (CDC)–funded HIV testing and service delivery in correctional facilities.

Methods:

Data on HIV testing and service delivery were submitted to CDC by 61 health department jurisdictions in 2013. HIV testing, HIV positivity, receipt of test results, linkage, and referral services were described, and differences across demographic characteristics for linkage and referral services were assessed. Finally, trends were examined for HIV testing, HIV positivity, and linkage from 2009 to 2013.

Results:

Of CDC-funded tests in 2013 among persons 18 years and older, 254,719 (7.9%) were conducted in correctional facilities. HIV positivity was 0.9%, and HIV positivity for newly diagnosed persons was 0.3%. Blacks accounted for the highest percentage of HIV-infected persons (1.3%) and newly diagnosed persons (0.5%). Only 37.9% of newly diagnosed persons were linked within 90 days; 67.5% were linked within any time frame; 49.7% were referred to partner services; and 45.2% were referred to HIV prevention services. There was a significant percent increase in HIV testing, overall HIV positivity, and linkage from 2009 to 2013. However, trends were stable for newly diagnosed persons.

Conclusions:

Identification of newly diagnosed persons in correctional facilities has remained stable from 2009 to 2013. Correctional facilities seem to be reaching blacks, likely due to higher incarceration rates. The current findings indicate that improvements are needed in HIV testing strategies, service delivery during incarceration, and linkage to care postrelease.

View the paper online: [Abstract](#)

Condom Use Errors and Problems: A Comparative Study of HIV-Positive Versus HIV-Negative Young Black Men Who Have Sex With Men

Crosby R, Mena L, Yarber WL, et al. *Sex Transm Dis* 2015;42(11):634-636

Objectives:

To describe self-reported frequencies of selected condom use errors and problems among young (age, 15–29 years) black men who have sex with men (YBMSM) and to compare the observed prevalence of these errors/problems by HIV serostatus.

Methods:

Between September 2012–October 2014, electronic interview data were collected from 369 YBMSM attending a federally supported sexually transmitted infection clinic located in the southern United States. Seventeen condom use errors and problems were assessed. χ^2 Tests were used to detect significant differences in the prevalence of these 17 errors and problems between HIV-negative and HIV-positive men.

Results:

The recall period was the past 90 days. The overall mean (SD) number of errors/problems was 2.98 (2.29). The mean (SD) for HIV-negative men was 2.91 (2.15), and the mean (SD) for HIV-positive men was 3.18 (2.57). These means were not significantly different ($t = 1.02$, $df = 367$, $P = 0.31$). Only 2 significant differences were observed between HIV-negative and HIV-positive men. Breakage ($P = 0.002$) and slippage ($P = 0.005$) were about twice as likely among HIV-positive men. Breakage occurred for nearly 30% of the HIV-positive men compared with approximately 15% among HIV-negative men. Slippage occurred for approximately 16% of the HIV-positive men compared with approximately 9% among HIV-negative men.

Conclusions:

A need exists to help YBMSM acquire the skills needed to avert breakage and slippage issues that could lead to HIV transmission. Beyond these 2 exceptions, condom use errors and problems were ubiquitous in this population regardless of HIV serostatus. Clinic-based intervention is warranted for these young

men, including education about correct condom use and provision of free condoms and long-lasting lubricants.

View the paper online: [Abstract](#)

GYT: Get Yourself Tested Campaign Awareness: Associations With Sexually Transmitted Disease/HIV Testing and Communication Behaviors Among Youth

McFarlane M, Brookmeyer K, Friedman A, et al. *Sex Transm Dis* 2015;42(11):619-624

Background:

The GYT: Get Yourself Tested campaign promotes sexually transmitted disease (STD) and HIV testing and communication with partners and providers among youth. We evaluated these behaviors in relation to campaign awareness among youth through a national survey.

Methods:

We collected data from 4017 respondents aged 15 to 25 years through an online panel survey designed to be representative of the US population. The GYT campaign targeted 4 key behaviors: STD testing, HIV testing, talking to partners about testing, and talking to providers about testing.

Results:

Respondents who were aware of the GYT campaign (24.4%) were more likely to report engaging in each of the 4 target behaviors. Associations remained significant when stratified by race and sex and when taking into account sexuality, sexual activity, age, insurance status, and use of campaign partner-provided services.

Conclusions:

Awareness of the GYT campaign is related to the 4 target behaviors promoted by the campaign, suggesting that health promotions campaigns oriented toward youth can be successful in increasing STD-related, health-seeking behavior, including among populations disproportionately affected by STD.

View the paper online: [Abstract](#)

Catching Up or Missing Out? Human Papillomavirus Vaccine Acceptability Among 18- to 26-Year-old Men Who Have Sex With Men in a US National Sample

Cummings T, Kasting ML, Rosenberger JG, et al. *Sex Transm Dis* 2015;42(11):601-606

Background:

Men who have sex with men (MSM) are disproportionately affected by human papillomavirus (HPV)-related outcomes and would benefit from HPV vaccination in adolescence. We assessed HPV vaccine attitudes, uptake, and barriers in this high-risk young MSM (YMSM) population.

Methods:

An online US sample of 1457 YMSM aged 18 to 26 years were recruited in December 2011 to examine HPV vaccine acceptability and uptake. The online survey included sociodemographics, HPV vaccine attitudes, acceptability, HPV vaccination status, health care use, and HPV knowledge.

Results:

Despite high use of health care in the past year (86%) and high acceptability (87.8/100) for free HPV vaccine, only 6.8% had received one or more vaccine doses. In addition, only 4% of unvaccinated men had been offered the vaccine by their health care provider (HCP). In a multivariate regression of unvaccinated men, increased vaccine acceptability was associated with an HCP recommendation, worry about getting infected with HPV, and being tested for a sexually transmitted disease in the past year, whereas safety concerns, lower perceived risk of infection, and shame associated with HPV infection/disease were associated with decreased vaccine acceptability. Through logistic regression, vaccine uptake was associated with being tested for a sexually transmitted disease in the past year, disclosure of being gay or bisexual to a doctor, and greater HPV knowledge.

Conclusions:

Health care providers need to use routine points of contact with YMSM patients to vaccinate against HPV. These data indicated missed opportunities to vaccinate YMSM who are open to HPV vaccination. In the future, HCPs of YMSM should be careful to avoid missed opportunities to vaccinate.

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

Resources, Webinars, & Announcements

QuickStats: Average Age at Death from HIV Disease, by Sex — United States, 1987–2013

CDC MMWR Nov. 5

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

During 1987–2013, the average age at death from HIV disease increased steadily for both males and females. The average age at death increased 34.0% among males, from 37.9 years in 1987 to 50.8 years in 2013. Among females, the average age at death increased 41.2%, from 35.2 years in 1987 to 49.7 years in 2013. Throughout the period, the average age at death from HIV disease for males was higher than that for females.

Expert Commentary: Three Different Perspectives On Trichomoniasis Screening

National Chlamydia Coalition

To view and download the Expert Commentary, [click here](#).

ANALYSIS: Making The Pill Available Over The Counter Should Be Part Of Broader Strategy To Enhance Contraceptive Access

Guttmacher Institute

The evidence strongly supports making oral contraceptive pills available without a prescription, but any effort to do so should complement—rather than replace—policies to reduce barriers to contraceptive use, argues a [new analysis in the *Guttmacher Policy Review*](#). In particular, moving the pill to over-the-counter (OTC) status should be done alongside important safeguards, such as ensuring insurance coverage for OTC contraceptives and not imposing medically unnecessary age restrictions.

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

2015 NHPC Conference Program Book is Now Available Online!

[Download the NHPC program book](#) on the NHPC conference site to get started with planning your conference experience!

As a reminder, **online registration** for NHPC closes on **November 16**. After November 16, only onsite registration will be available.

Want to know more? Check the [NHPC website](#) often for conference updates. You can also join the conversation using the hashtag **#NHPC2015** and follow developments on the [CDC HIV Facebook page](#).

WEBINAR: LARCs and More: A Comprehensive Contraceptive Update with Dr. Erin Saleeby!

DATE: Nov. 30

TIME: 12:00 – 1:00 PM PST

Presenter:

Erin Saleeby, MD, MPH, Medical Director, California Family Health Council and Director of Women's Health Programs and Innovation for LA County Department of Health Services

Overview:

This session will review the latest developments in contraceptive practice, including a description of the available FDA-approved methods and emergency contraception. The discussion will include strategies for applying the latest evidence-based recommendations for contraceptive management across all tiers of effectiveness and will consider factors that affect contraceptive efficacy in certain patients.

Techniques for utilizing the U.S. Medical Eligibility Criteria (MEC) and the Selected Practice Recommendations for Contraceptive Use will also be discussed and how these tools can facilitate shared decision making that helps women choose the best contraceptive method for them to reduce unintended or unplanned pregnancy.

What Will You Learn?

After attending this training, participants will be able to:

- Describe the benefits, risks, and side effects of the available contraceptive methods
- Utilize a tiered effectiveness counseling approach to introduce patients to all of their contraceptive options in a time-sensitive manner
- Utilize the U.S. Medical Eligibility Criteria (MEC) and the Selected Practice Recommendations for Contraceptive Use to assist women with specific medical conditions in choosing an appropriate contraceptive option

Who Should Attend?

- Physicians
- Clinicians
- Nurses
- Certified Nurse Midwives
- Family Planning Staff
- Medical Assistants
- Health Educators + Counselors

FREE Continuing Education will be provided for CME, Nursing, Social Work and CHES

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

Job/Internship Postings

Social Work Supervisor - Tuberculosis Control Program, San Mateo County Health System

Organization: San Mateo County Health System
Location: San Mateo, CA
Salary: \$6,921 - \$8,651 /Month
App. Deadline: December 1, 2015

THE POSITION

The San Mateo County Health System is seeking a well-qualified individual for the position of **Social Work Supervisor - Tuberculosis Control Program**. Under the direction of the Senior Public Health Nurse, this position will plan, assign, review, and evaluate the work of the program staff including Communicable Disease Investigators and Community Workers.

The current vacancy is in the Public Health, Policy and Planning Division's Disease Control and Prevention Unit Tuberculosis (TB) Control Program located in San Mateo, CA, but may travel throughout the County to attend meetings or perform other job duties.

Primary responsibilities will include:

- Provide guidance and support for TB Control staff in regards to addressing psycho-social needs of clients (i.e. food, housing, employment, transportation, and legal).

- Plan, assign, review, and evaluate the work of assigned TB Control personnel including Communicable Disease Investigators and Community Workers.
- Assist TB Control staff in developing and improving contact investigation, immigration clearance, and direct observed therapy skills.
- Coordinate individual and group staff meetings to discuss general policies, rules, regulations, or laws relating to the TB Control program.
- Coordinate individual client case conferences with staff to discuss specific issues with caseload and develop care plans for individual clients.
- Participate in development of guidelines, protocols, and policies; incorporating social work methodologies and practices.
- Review contact investigation plans and summaries.
- Coordinate the workload of direct reports with other program or departmental units providing related services.
- Meet with higher level management on departmental policies, practices, and procedures.
- Confer with and provide information to other public and private agencies interested in the programs and services of the department.
- Orient new TB Control staff to program protocols and policies.
- Participate in on-going quality improvement activities.
- Prepare reports and correspondence.
- Conduct effective fact gathering interviews of a highly personal nature as needed.
- Perform related duties as assigned.

The **ideal candidate** will possess:

- A Master's degree in Social Work or related field.
- Supervisory experience with strong leadership skills to direct the work of and motivate the team.
- Familiarity with the laws, rules, regulations and procedures governing the operation of TB Control programs, public social services agencies and various service programs.
- Ability to maintain effective, cooperative, and professional relationships with clients from a variety of diverse backgrounds, representatives of other units and agencies, and others contacted during the course of work.
- Strong organizational skills and the ability to plan and implement program services.
- Knowledgeable of principles of case management, including the integration of psycho-social and health related issues and services.
- Analytical and problem solving skills, with an ability to exercise sound judgment in decision-making.
- Experience in preparing and presenting oral and written reports.

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

QUALIFICATIONS

Education and Experience: Any combination of education and experience that would likely provide the required knowledge, skills and abilities is qualifying. A typical way to qualify is two years of experience performing a full range of professional social worker duties.

Knowledge of: Principles, methods, and techniques of social work; principles, practices, and techniques of Public Health; laws, rules, regulations, and procedures governing the operation of public social service

agencies and the variety of service programs; principles of individual and group behavior and their application to cases; community organizations and resources; and functions of social welfare agencies; basic knowledge of transmission, diagnosis, and treatment of communicable diseases.

Skill/Ability to: Plan, organize, assign, supervise, and evaluate the work of assigned staff; provide direction in the development and implementation of treatment plans for clients; effectively interpret departmental policies, rules, and regulations; prepare and present clear and concise oral and written reports; maintain effective, cooperative, and understanding work relationships with clients from a variety of racial and ethnic backgrounds and representatives of other units and agencies; exercise initiative and tact in tracing contacts and bringing them to obtain treatment; relate easily to people from diverse cultures and varying lifestyles; apply the rules and regulations relative to communicable disease control; and establish and maintain effective working relationships with those contacted in the course of the work.

APPLICATION/EXAMINATION

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

The examination will consist of an interview (weight: 100%). Depending on the number of applicants, an application appraisal of education and experience may be used in place of other examinations or a screening committee may select those applicants whose education and/or experience appear to best meet the needs of the position based solely on the information provided in the application documents. Because of this screening process, all applicants who meet the minimum qualifications are not guaranteed advancement to the next phase of the examination process.

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

For more information: [Click here](#)

Aaron Kavanaugh

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

Tel: 510-620-3402

Fax: 510-620-3180

Web: std.ca.gov

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