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California Stories

STD rate in San Diego County rises

Sandra Phillips, Fox San Diego | 1.7

The number of cases of gonorrhea and syphilis increased in the San Diego region in 2014, compared to the previous year, but the region bucked a national trend with the rate of chlamydia infections dropping, county health officials said today.

Gonorrhea cases jumped 18 percent, from 2,865 cases in 2013 to 3,391 cases in 2014, the last year for which final statistics are available.

The rate of gonorrhea in men was more than double that of woman. Men between the ages of 20 and 29 had the highest rate of infection, according to the county.

The number of syphilis infections climbed 6 percent, from 347 cases in 2013 to 369 in 2014.

The majority of syphilis cases were reported in men, especially men who have sex with other men. Black men had the highest rate of infection, almost double that of white males, county health officials said.

“Gonorrhea and syphilis cases increased across the nation in 2014, and San Diego was no exception,” said Dr. Wilma Wooten, the county public health officer. “It is important that sexually active people continue to take precautionary measures to avoid getting infected with these and other sexually transmitted diseases.”

Gonorrhea and syphilis cases also increased nationwide, as did chlamydia.

However, the number of chlamydia cases in 2014 in San Diego County fell for the second year in a row, from just over 16,000 to 15,626. Chlamydia is the most prevalent STD in the region, and is found in twice as many women as men.

“Young women between 15 and 24 years of age have the highest rate of chlamydia infections,” said Dr. M. Winston Tilghman, senior physician and STD controller for the county. “Chlamydia and gonorrhea both can result in infertility and other long-term reproductive health issues, which make prevention particularly important in this age group.”

The county offers a free home testing program for gonorrhea and chlamydia, available to women 25 years old and younger. The program can be accessed online at DontThinkKnow.org or by calling 619-692-5669.

The county also participates in a program that screens young women entering San Diego’s juvenile detention facility for STDs and provides treatment to those who have a positive test.

Four STD clinics are operated by the county, offering testing and treatment for most STDs regardless of a patient’s ability to pay. More information about STDs and testing services are available at STDSanDiego.org, or 619-293-4700.

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

Gonorrhea infections on the rise among residents in the past 5 years in Santa Cruz County

Bay City News, KRON4 | 12.19

Santa Cruz County has seen an increase in among its residents within the past five years, according to data released Friday by county public health officials.

In November, there were 29 reported cases of the sexually transmitted disease, twice the monthly average of 15 from January to October, according to public health officials.

The November number is also the highest monthly total dating back from 2010, public health officials said.

There has also been a steep growth in annual cases from 46 in 2010 to 178 in 2014, public health officials said.

The rise in infections was seen across genders, ages and ethnicities, according to public health officials.

The category with greatest increase over the past few months was among men between the ages of 18 and 35 who have sex with other men, public health officials.

The disease is common among people ages 15 to 24 and is spread by having sex with an infected person, according to the Centers for Disease Control and Prevention.

Gonorrhea can be cured with antibiotics, but if untreated can lead to serious health complications, CDC officials said.

To avoid catching the disease people are advised to use a condom during intercourse, reduce the number of sex partners and getting tested for the STD, according to CDC officials.

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National Stories

Republicans in Congress ended the decades-long funding ban on needle exchange programs

German Lopez, Vox | 1.6

In December, Congress quietly made a huge change to help combat HIV: It effectively lifted the federal funding ban on needle exchange programs, which provide clean needles — meaning syringes that aren't infected with HIV — to drug users.

The change, reported by John Stanton at BuzzFeed on Tuesday, keeps the federal funding ban on syringes themselves, but ends the ban on all other aspects of the programs — staff, vehicles, gas, rent, and so on. Activists praised the move as an effective end to the ban, since the syringes are a very inexpensive part of needle exchange programs.

The ban's end was spearheaded by two Kentucky Republicans, House Appropriations Chair Hal Rogers and Senate Majority Leader Mitch McConnell, in large part as a response to an HIV crisis in Indiana and a heroin epidemic nationwide. Last year, the worst ever HIV epidemic in Indiana prompted Republican Gov. Mike Pence to allow needle exchange programs in his state. And with the worsening heroin epidemic, federal lawmakers were purportedly worried that growing addiction to the needle-injected drug could make HIV spread further.

Congress originally imposed the ban in the late 1980s in response to the HIV/AIDS epidemic of that era, based on now-disproven concerns that providing clean needles to drug addicts could enable more drug use and make drug and HIV epidemics worse. Congressional Democrats briefly lifted the ban in 2009, but Republicans put it back in place in 2011 after they took over the House of Representatives.

Clean needle exchanges are a proven way to fight the spread of HIV

Syringe exchanges allow people to obtain clean needles for little to no cost. The idea is to get dirty needles off the streets while supplying drug users with needles that won't carry the risk of an HIV or hepatitis infection.

These programs are proven to substantially reduce, although not eliminate, the rate of HIV infections from needles. A 1998 study from researchers at Johns Hopkins University found clean needle exchanges generally reduced the spread of HIV without increasing drug use. A 2004 study from the World Health Organization, which analyzed two decades of evidence, produced similar results.

When Washington, DC, adopted a needle exchange program to combat its HIV epidemic, needle-caused HIV cases dropped by 80 percent, from 149 in 2007 to 30 in 2011, according a report from the DC Department of Health.

Critics of needle exchanges argue the programs increase illegal drug use by expanding access to syringes used for drugs. But the World Health Organization's 2004 review of the research found no convincing evidence to support that claim.

The end of the congressional funding ban essentially comes around to this research — right as there are signs that these programs are needed the most.

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Recommended STD Testing Received By Less Than Half Of Teen Sexual Assault Victims Who Go To The ER

Ed Cara, Medical Daily | 12.30

It seems that even in the emergency room, young sexual assault survivors aren't receiving the medical care they deserve.

According to a study published this December in *Pediatrics*, more than half of teenagers who visit the emergency department (ED) after a sexual assault aren't given testing for sexually transmitted diseases (STDs) like gonorrhea and chlamydia, nor are they given preventative STD medication like antibiotics (prophylaxis). These gaps both fall spectacularly short of the guidelines issued by the Centers for Disease Control and Prevention (CDC), which recommend that all sexual assault survivors, young and old, are given testing and prophylaxis at the first opportune moment of medical evaluation.

"Evaluation and treatment of adolescent sexual assault victims varied widely across pediatric EDs," the authors concluded.

The researchers, led by Dr. Samantha Schilling of the Children's Hospital of Philadelphia, delved into data taken from the Pediatric Hospital Information System, which provides information on the utilization of resources from 45 different children's hospitals. They then narrowed in on 12- to 18-year-olds who were diagnosed with sexual assault at one of 38 emergency departments from 2004 to 2013, ultimately finding 12,687 such cases. Of these, more than nine out of 10 were women, 80 percent were under the age of 16, and nearly 60 percent were black or hispanic.

In total, only 44 percent received testing for gonorrhea, chlamydia, and pregnancy, and 35 percent received prophylaxis and emergency contraception. The rate of testing at different EDs ranged from 6 to 89 percent, and from a whopping 0 to 57 percent for prophylaxis. About the only shining bit of good news was that testing and prevention was more likely in EDs that had a specialized protocol for sexual assault survivors in place, such as available victim support services. After adjusting for other factors, survivors at these EDs were 50 percent more likely to receive prophylaxis than elsewhere.

It should be noted the study's findings are only an indication of whether the survivor in question went through with these options, not whether it was offered in the first place. As noted by the CDC, the experience of STD or pregnancy testing after sexual assault can be retraumatizing for some, so it isn't surprising to see varying rates. On the other hand, a 2007 study of Rhode Island hospitals found that nearly all adult sexual assault survivors who were offered testing and prophylaxis by ED personnel chose to take it, save for HIV prophylaxis. Though the current study didn't measure for it, testing for HIV, along with Hepatitis B and syphilis, is also recommended by the CDC, while HIV prophylaxis is an optional step. While the chances of contracting STDs or becoming pregnant from a singular sexual assault are relatively low, it's obviously and easily preventable with prompt treatment.

Given that EDs with better understanding of how to counsel survivors had better treatment rates, it's fair to say that many EDs aren't doing the best they can to help these already mistreated patients.

Journal Reference:

Schilling S, Samuels-Kalow M, Gerber J, et al. Testing and treatment after adolescent sexual assault in pediatric emergency departments. *Pediatrics*. [ABSTRACT](#)

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

Strong recommendations for HPV vaccine lacking among pediatricians, family practitioners

Casey Hower, Healio | 1.5

Nearly one-third of physicians reported not strongly recommending HPV vaccination at patients' 11-12 year well visit, and they were even less likely to recommend the vaccination for boys, according to recently published data.

Researchers conducted a nationally representative survey of pediatricians (n = 582) and family practitioners (n = 364) to assess self-reported practices for recommending and administering HPV vaccine, and to determine frequency of parental deferral of HPV vaccination.

Results demonstrated that 60% of pediatricians and 59% of family practitioners reported strongly recommending HPV vaccine for girls aged 11 to 12 years. For boys aged 11 to 12 years, 52% of

pediatricians and 41% of family practitioners strongly recommended the HPV vaccination. Eighty-four percent of pediatricians and 75% of family practitioners reported frequently or always discussing HPV vaccination at patients' 11-12 year well visit, according to the researchers.

Physicians who occasionally or never discussed HPV vaccination at well visits were more likely to be family practitioners (aOR = 2; 95% CI, 1.1-3.5), be male (aOR = 1.8; 95% CI, 1.1-3.1), disagree that parents will accept HPV vaccine if discussed alongside other vaccinations (aOR = 2.3; 95% CI, 1.3-4.2), report that between 25% and 49% (aOR = 2.8; 95% CI, 1.1-6.8) or more than 50% of parents defer vaccination (aOR = 7.8; 95% CI, 3.4-17.6) and express concern about waning immunity (aOR = 3.4; 95% CI, 1.8-6.4), according to the researchers.

More than half of surveyed physicians reported that HPV vaccination was deferred by more than 25% of parents, according to the researchers.

The researchers noted that further public health efforts may help combat parental deferment of HPV vaccination.

“Our results indicate that physicians themselves may need a clearer understanding of the reasons to vaccinate against HPV at 11 to 12 years old vs. later in adolescence and the reasons to vaccinate boys. In addition, physicians may need guidance on discussing these reasons with parents. Future research could investigate whether public health efforts directed at parents, education of physicians by professional organizations, and tools from the CDC and professional organizations will increase physicians' discussion of the HPV vaccine and strength of recommendation for 11- to 12-year-old girls and boys,” Allison and colleagues concluded.

Journal Reference:

[Allison MA, et al. *Pediatrics*. 2015;doi:10.1542/peds.2015-2488.](https://doi.org/10.1542/peds.2015-2488)

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

Gonorrhea may soon be untreatable, Britain's chief medical officer warns

Rachel Feltman, The Washington Post | 12.28

Dame Sally Davies, Britain's chief medical officer, has reportedly written to doctors and pharmacies in Britain sounding the alarm on antibiotic resistant gonorrhea.

The sexually transmitted infection is increasingly caused by strains of *Neisseria gonorrhoeae* that resist antibiotic treatment. “Gonorrhoea is at risk of becoming an untreatable disease due to the continuing emergence of antimicrobial resistance,” Davies wrote. The Guardian reports that a recent outbreak of a superbug strain of the disease — one that doesn't respond to the antibiotic azithromycin — has put Britain on high alert.

Davies urged doctors to use proper treatment protocols. A recent study found that many doctors in Britain still prescribe ciprofloxacin, which hasn't been recommended for a decade now.

Things aren't much better in the United States: In 2013, the Centers for Disease Control and Prevention gave it the centers' highest ranking for antibiotic resistance, classifying gonorrhea as an "urgent threat." At that time, the CDC reported that around a third of cases were resistant to at least one antibiotic.

In the United States, there were just over 350,000 cases in 2014; Britain had about 35,000.

Doctors in the United States are now told to use a combination of the antibiotics ceftriaxone and azithromycin. For a while, this strategy seemed to be working: A recent study found that resistance to ceftriaxone, a marvelously effective drug at the time of its release, had dropped from 1.4 percent of gonorrhea cases in 2011 to just .4 percent in 2013. But in 2014, the resistance doubled.

Why does this happen? When researchers look for new antibiotics, they obviously look for ones that are incredibly effective against pathogenic bacteria. But as soon as these antibiotics are released for use by the public, they start to lose their effectiveness. Bacteria are fast-evolving creatures, and individual bacterium are skilled at sharing genes that allow them to survive particular antibiotics. Bacteria can even copy resistance genes from microbes of different strains and species through a process called horizontal gene transfer.

Historically, humans haven't done much to slow this process. Whenever you take antibiotics you don't need, you're introducing bacteria in your body and your environment to the drug, giving those microbes an opportunity to learn resistance to it. Whenever you don't finish an entire prescription of antibiotics, you're leaving behind bacteria that showed some resistance to the first few days of treatment, and allowing them to reproduce. When farmers treat healthy livestock with antibiotics in order to promote growth, they're breeding resistance in our meat and in our soil. Now that we know how dangerous this process is, it may be too late to stop it.

It's possible that scientists will develop new classes of antibiotics that are less likely to fall into this cycle. But for the most part, this is just how bacteria work — so it's our use of antibiotics that really has to evolve.

Antibiotic resistant gonorrhea has an especially creepy ring to it. Sexually transmitted infections are highly stigmatized, so the idea of one you can't get rid of with standard treatment is understandably scary. But as scary as it is, gonorrhea is hardly the biggest of our worries when it comes to antibiotic resistance. This problem isn't going to go away.

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Why a Drug to Prevent HIV Infection Is in Low Demand

Public-health officials push wider use of PrEP, but some AIDS organizations lobby against the medication
Sumathi Reddy, The Wall Street Journal | 12.21

Public-health officials are pushing for much wider use of a drug that has proved effective at preventing HIV infection.

PrEP, or preexposure prophylaxis, is a daily medication that people at high risk for HIV can take to protect against acquiring the virus, which causes AIDS. The drug Truvada was approved by the Food and

Drug Administration in 2012 for use as PrEP. About 50,000 people a year in the U.S. become infected with HIV, according to the Centers for Disease Control and Prevention.

Still, fewer than 22,000 people are estimated to have taken PrEP for prevention, according to an analysis this year in the journal *Current Opinion in HIV and AIDS*. AIDS remains a significant cause of death in certain populations although treatments have made living with the syndrome a reality for many.

The CDC in November released a report suggesting some 1.2 million U.S. adults who are at substantial risk for acquiring HIV could benefit from PrEP. Among those are one in four gay and bisexual men; one in five people who inject drugs; and one in 200 sexually active heterosexuals.

Taking PrEP reduces the risk of HIV infection through sexual transmission by as much as 92% and by about 70% in people who inject drugs, the CDC says. Still, one in three primary care doctors haven't heard of the medication, according to a 2015 CDC survey.

The agency has issued clinical guidelines with charts and checklists to assist health-care providers during patient evaluations, and offers a telephone hotline for people to get free expert clinical advice on PrEP. "As with any new health intervention, it will take time for people to learn about and become comfortable with PrEP," a CDC spokeswoman said.

"More high-risk individuals need to know about the benefits of PrEP and more physicians need to know about it," said Carlos del Rio, chairman of the Infectious Disease Society of America's HIV Medicine Association and a professor at Emory University. "We can really decrease the number of new HIV infections if PrEP is used more."

PrEP can cost between \$8,000 and \$14,000 a year, although it is covered by most private insurers and by Medicaid in many states. Assistance programs, including one from Gilead Sciences, the maker of Truvada, are available for those without insurance. The drug, which is also used in HIV treatment, has mostly minimal side effects, doctors say.

Some AIDS organizations don't promote use of the drug, partly out of concern it could encourage more risky sexual behavior. "We are having an explosion of other sexually transmitted diseases impacting the gay community and PrEP offers no protection whatsoever for any other disease," said Ged Kenslea, communications director for AIDS Healthcare Foundation, a Los Angeles-based global AIDS organization.

Mr. Kenslea said the group disagrees with the CDC's goal of getting 1.2 million people on PrEP. "The patient must take the [PrEP] pill; we can't even get people who are already HIV positive to take their pills every day," he said. The foundation last week began a national ad campaign, entitled "PrEP: The Revolution That Didn't Happen," in gay and lesbian publications in major cities. It aims in part to encourage the CDC to focus on other prevention methods, such as condoms, and to devote its resources to HIV treatment.

Research has shown PrEP's effectiveness. A continuing randomized controlled trial in England, which has been following more than 500 men at risk for contracting HIV, found that participants taking PrEP were 86% less likely to get infected than those not on the drug. The study, published in the journal *the Lancet* in September, also found that the people on PrEP reported more unprotected sex, but there was no evidence of an increase in sexually transmitted diseases.

Researchers at Kaiser Permanente in California followed 657 noninfected people taking PrEP for an average of seven months and found none of the participants contracted HIV, said Jonathan Volk, lead author of the study and a physician with Kaiser Permanente San Francisco Medical Center. “That’s really compelling data on how effective this medication is,” he said.

After one year on PrEP, however, about half of the users were diagnosed with at least one sexually transmitted disease. And nearly half the participants in a representative subset said they used condoms less frequently after starting PrEP, Dr. Volk said. The study was published in September in the journal *Clinical Infectious Diseases*.

Albert Liu, a clinical research director at the San Francisco Department of Public Health, said a study he led shows that most people will take PrEP as prescribed if they have access to the medication. San Francisco has made efforts to expand the availability of PrEP over the past year, including offering it in a number of clinics.

The study, published in November in *JAMA Internal Medicine*, followed 557 gay men and transgender women who were provided PrEP for a year in clinics in San Francisco and Miami and a community health center in Washington, D.C. More than 80% of the participants had protective levels of PrEP in their bloodstream, suggesting a high level of adherence to the medication regimen, Dr. Liu said.

The study also found that among the participants, “risky behavior either declined or remained the same,” Dr. Liu said.

“My belief is that PrEP doesn’t change people’s behavior,” said Paul Marcelin, a 41-year-old software engineer in Alameda, Calif., who has been taking the drug since July 2013.

Mr. Marcelin said more people in the gay community have begun advertising if they are on PrEP in online- and social-media-dating profiles. “Now, [PrEP] is much more commonplace, at least in San Francisco,” he said.

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Lessons learnt from the history of contraception are relevant for the implementation of PrEP

Roger Pebody, aidsmap.com | 1.6

Achieving a widespread and appropriate use of pre-exposure prophylaxis (PrEP) will take several years and will require considerable attention to the shape and quality of health services, according to researchers who have looked at the way in which contraceptive methods have been introduced.

“With five decades of experience with development and implementation, contraception has a lot to offer the PrEP field in terms of lessons learned for new method introduction,” Sinead Delany-Moretlwe and colleagues write in the January issue of *Current Opinion in HIV & AIDS*. “A narrow focus on promotion of a new technology alone will not increase choice; service delivery systems and providers are equally important to the success of PrEP introduction.”

The introduction of the pill

This is not the first time that the history of contraception has been reviewed in order to identify parallels with PrEP. Writing three years ago in *Clinical Infectious Diseases*, Julie Myers and Kent Sepkowitz noted that American controversies about the oral contraceptive pill are similar to those surrounding the introduction of PrEP.

Prior to its introduction in the United States in 1960, many doubted that large numbers of women would want to take a medication in order to prevent pregnancy and pharmaceutical companies did not believe the market had much potential. Scale-up was slowed by its high initial cost, equivalent to around \$80 a month in today's prices. This, together with a need for regular clinic visits, created economic and logistical hurdles that only more socially privileged women could overcome, say Myers and Sepkowitz.

After some years, subsidised programmes and government funding helped to narrow inequalities in access. Moreover media coverage, word of mouth endorsement and promotion by pharmaceutical companies led to a swell of interest and acceptance. Women actively sought out the pill from their doctors.

Similarly, the high cost of PrEP makes it controversial with some, publicly funded PrEP programmes are only available in a few areas, and there is a risk that its use may exacerbate health disparities by only protecting those able to afford it. Since the article was published, awareness of PrEP has grown considerably in gay communities.

As with PrEP, there was concern about the potential side-effects of the contraceptive pill, as medications taken by healthy people are expected to be safer than those used to treat an illness. While the contraceptive pill's short-term side-effects were understood, its long-term safety profile was initially unclear. Evidence of a raised risk of deep vein thrombosis only emerged after a few years and resulted in necessary changes in the way the pill was prescribed.

The authors note that, as with initial contraceptive research, most participants in PrEP studies were located outside of the US. "While safety seems promising for emtricitabine-tenofovir, we should expect some surprises as use is scaled up to populations who were not included in the clinical trials," they argue.

Most famously, the contraceptive pill was thought by some to promote promiscuity and to have caused a 'sexual revolution' in the 1960s and 1970s. Similarly, some predict that PrEP will result in reductions in condom use and increases in sexually transmitted infections.

However the authors suggest that both claims ignore gradual, ongoing changes in sexual norms that had begun before the new medical technologies were introduced. "Changes in behavior should not automatically be blamed on the new HIV prevention pill," they say.

Method mix and health services

The more recent article, published by Sinead Delany-Moretlwe and colleagues in *Current Opinion in HIV & AIDS*, draws on some of the more recent history, especially in lower and middle income countries.

They note that increasing choice by introducing new contraceptive products has been seen as key to increasing the use of contraception. In places where a wide range of delivery systems are available, both short-acting (e.g. pills and diaphragms) and long-acting (e.g. implants and injections), usage tends to be higher.

This suggests that adding PrEP to the range of HIV prevention options that are already available will increase the number of people who are protected in some way from HIV. Moreover, the option of non-daily dosing of PrEP, and the possible future development of PrEP as a long-acting injection or a vaginal ring, would increase usage.

Despite such innovations, adherence may remain imperfect. Even among women using contraceptive injections, discontinuation rates are high, users often switch between methods and are frequently late for their next injection. In some cases, this is due to failings in health services. For example services may be difficult or costly to access, or staff may not have warned users about the potential for side-effects.

Delany-Moretlwe warns that if health services are unable or unwilling to deliver new health technologies with good quality care then the potential of the new products may not be realised. “Too often, the focus on product development leads to a focus on a single technology, and not on investing in the larger programmatic and policy initiatives that are essential to product uptake and use,” she says.

The first-generation of oral PrEP products have complex requirements, including monitoring for side-effects and drug resistance. While this may suggest delivery by providers with experience of antiretrovirals, they may not reach those needing PrEP.

“The channels through which products reach users are important for ensuring access,” the authors say. Programmes which attempt to integrate PrEP into existing HIV prevention programmes or health services – such as reproductive health services for women – will need to be carefully evaluated. The experience with contraception shows that institutional changes to health services are difficult to achieve and to maintain, for example when the results from pilot projects are transferred to larger settings.

In contraception, medical barriers to access have been removed as increasing evidence of safety has emerged. Products may be available over the counter or through community-based distribution agents. Although this expanded access has occasionally been at the cost of lower-quality provision and monitoring, similar efforts will need to be made for PrEP. “All possible mechanisms for providing access to PrEP will need to be explored to ensure that PrEP is accessible to those with the greatest need,” Delany-Moretlwe argues.

Both contraception and PrEP draw attention to the broader social, economic, and political context in which sexual relationships occur. Although they both have the potential to be empowering technologies, uptake may be limited where gender inequalities are strong. Adolescents may be prevented from accessing contraception by official policies or due to healthcare providers’ personal views about young people’s sexual activity. Marginalised ‘key populations’ such as sex workers and men who have sex with men may have particular barriers to accessing health services.

But the authors say that if PrEP is primarily offered to specific groups, such as sex workers, then this risks undermining wider acceptance of the product. This has sometimes occurred with female condoms, but has in other countries been avoided by providing female condoms in family planning clinics. If PrEP is to be successfully introduced, the needs and views of all users will need to be carefully considered.

The authors warn against expectations that PrEP will be an overnight success. Several different contraceptive methods have taken decades to be widely used, showing that slow initial uptake of a product should not be interpreted as a fundamental problem with acceptability. Products which require

different practices from users, communities or healthcare providers may take some time to get off the ground.

Conclusion

PrEP advocates can learn many lessons from contraception, Sinead Delany-Moretlwe argues. “Perhaps the most important of these is that a narrow focus on a single technology alone is unlikely to solve health and social challenges associated with HIV. That, however, is no cause for inaction, but rather a call for innovation to expand the HIV prevention mix, to pay careful attention to access and service delivery issues and constraints, and to incorporate the views and perspectives of all stakeholders.”

References

Myers JE & Sepkowitz KA. A Pill for HIV Prevention: Déjà Vu All Over Again? *Clinical Infectious Diseases* 56: 1604-1612, 2013.

Delany-Moretlwe S et al. Planning for HIV preexposure prophylaxis introduction: lessons learned from contraception. *Current Opinion in HIV & AIDS* 11: 87–93, 2016.

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

Scientific Papers/Conference Abstracts

Women want Pre-Exposure Prophylaxis but are Advised Against it by Their HIV-positive Counterparts

Goparaju L, Experton LS, Praschan NC, et al. *J AIDS Clin Res* 2015;6:522

Objective:

The latest advancement in HIV prevention, Pre-Exposure Prophylaxis (PrEP), could reduce incidence among women. However, PrEP uptake has remained low among US women since its approval in 2012, while use has increased among men who have sex with men. This study addresses women’s knowledge, attitudes and potential behaviors regarding PrEP. While HIV-negative women are the potential users of antiretroviral (ARV) medications for PrEP, HIV-positive women who have used ARVs could contribute immensely to our understanding of the complexities related to taking such medications. This study is the first to synthesize the opinions of both groups of women.

Method:

We conducted eight focus group discussions, segregated by sero-status; four with at-risk HIV-negative (20) and four with HIV-positive (19) women in Washington DC during 2014. Topics discussed include PrEP awareness, likelihood of use, barriers and target populations.

Results:

PrEP awareness was almost non-existent and the HIV-negative women urged publicity. They expressed much enthusiasm about PrEP and wanted to use and recommend it to others despite recognizing potential complexities related to taking PrEP, such as side effects, access, duration and frequency of use. HIV-positive women were less supportive of PrEP for those same reasons based on their experience with

taking ARVs. They preferred condoms over PrEP given relative efficacy, affordability, accessibility, and prevention of other STIs.

Conclusion:

There is an urgent need for PrEP public health campaigns catered to the needs and concerns of women.

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

Modelling the Impact of Condom Distribution on the Incidence and Prevalence of Sexually Transmitted Infections in an Adult Male Prison System

Scott N, McBryde E, Kirwan A, et al. *PLOS One* 2015;

Aims:

To determine the effects of 1) a condom distribution program and 2) a condom distribution program combined with opt-out sexually transmitted infection (STI) screening on the transmission and prevalence of STIs in a prison system.

Methods:

Using data from an implementation evaluation of a state-wide prison condom program and parameter estimates from available literature, a deterministic model was developed to quantify the incidence and prevalence of sexually transmitted HIV, hepatitis B, chlamydia, syphilis and gonorrhoea across 14 Victorian prisons. The model included individual prison populations (by longer (>2 years) or shorter sentence lengths) and monthly prisoner transfers. For each STI, simulations were compared: without any intervention; with a condom distribution program; and with a combined condom and opt-out STI screening at prison reception intervention program.

Results:

Condoms reduced the annual incidence of syphilis by 99% (N = 66 averted cases); gonorrhoea by 98% (N = 113 cases); hepatitis B by 71% (N = 5 cases); chlamydia by 27% (N = 196 cases); and HIV by 50% (N = 2 cases every 10 years). Condom availability changed the in-prison epidemiology of gonorrhoea and syphilis from self-sustaining to levels unlikely to result in infection outbreaks; however, condoms did not reduce chlamydia prevalence below a self-sustaining level due to its high infectiousness, high prevalence and low detection rate. When combined with a screening intervention program, condoms reduced chlamydia prevalence further, but not below a self-sustaining level. The low prevalence of HIV and hepatitis B in Australian prisons meant the effects of condoms were predicted to be small.

Conclusion:

Condoms are predicted to effectively reduce the incidence of STIs in prison and are predicted to control syphilis and gonorrhoea transmission, however even combined with a screening on arrival program may be insufficient to reduce chlamydia prevalence below self-sustaining levels. To control chlamydia transmission additional screening of the existing prison population would be required.

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

Getting What You Pay For: The Economics of Quality Care for Sexually Transmitted Infections

Morgan JR, Drainoni ML, Sequeira S, et al. *Sex Transm Dis* 2016;43(1):18-22

Background:

Understanding the relationship between charges, reimbursement, and quality for sexually transmitted infection (STI) care is necessary to evaluate consequences of shifting patients from STI specialty to nonspecialty settings and to inform quality improvement efforts in this area.

Methods:

Chart reviews were used to evaluate quality of documented STI care among 450 patients across 5 different clinical settings within a large safety net hospital in Massachusetts for patients presenting with penile discharge/dysuria or vaginal discharge. Charges billed and recouped by the hospital for each visit were extracted from billing records. Univariate methods examined unadjusted differences between quality and other patient and practice characteristics, and charges billed and recouped, whereas a multivariable model predicted the effect of quality on charges and reimbursements after adjusting for potential confounders.

Results:

Higher documented quality of care was associated with higher charges, with each additional quality point predicting a 9% increase in visit charges. However, these charges were not recouped by the institution, as quality was not associated with higher levels of hospital reimbursement. Among sites of care, the STI clinic had the highest average quality score, as well as the lowest average amount billed and recouped.

Conclusions:

The relationship we find between documented quality and charges billed may reflect resource use for patient visits. The hospital, however, did not recoup any more on average from higher-quality visits, thus posing an incentive problem for the institution. Our findings suggest that loss of government funds for STI clinics may not be replaced by hospital billing and may lead to lower quality of care.

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

Resources, Webinars, & Announcements

February 7 is National Black HIV/AIDS Awareness Day

February 7, 2016: [National Black HIV/AIDS Awareness Day](#) is a national testing and treatment community mobilization initiative targeted at African Americans. This year's theme is "I am my Brother/Sister's Keeper. Fight AIDS/HIV." [Get involved or plan an event](#) to commemorate this special day!

New PrEP Toolkit for CBOs by AIDS United, CDC, and GMHC

AIDS United, in partnership with the Centers of Disease Control and Prevention (CDC) and Gay Men's Health Crisis (GMHC), is excited to announce the release of our [Pre-Exposure Prophylaxis \(PrEP\) Toolkit](#). This [toolkit](#) was created as a resource for staff in community-based organizations (CBOs) to support their efforts at educating communities about and increasing access to PrEP.

Issue Brief: Transgender Women and PrEP for HIV Prevention

The [National Center for Innovation in HIV Care](#) published an issue brief on transgender women and Pre-Exposure Prophylaxis (PrEP). This issue brief is an excellent resource to better understand how PrEP could prevent HIV infection in transgender women. [Download your copy today!](#)

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