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California Stories

Contra Costa Co. Prepares to Offer Health Care to Undocumented Adults

Tara Siler, KQED News | 11.17

Brookside Community Health Center in Richmond serves a lot of immigrants — with legal papers and without — and it's about to take on even more. Contra Costa County already provides insurance to undocumented children, and in September county supervisors voted to extend primary care services to 3,000 adults living here illegally.

The one-year pilot program, Contra Costa Cares, will offer coverage to 15 percent of those eligible.

Rosa Maria Arriaga, 72, has been living in Richmond as an undocumented immigrant for 24 years and was active in lobbying supervisors about the program. She says she needs treatment for asthma, depression and arthritis.

"The coverage would help me a lot," she says in Spanish, "because I could get my knee treated. The arthritis makes it so I can't walk. My asthma hits at night really hard, and when the depression comes on, I feel like it's better to die."

Regular primary care might help Arriaga get her health issues under better control. But she says that level of care has been out of reach.

"When there's an emergency, I go to a clinic," she says. "And each time it costs me \$45. We need medical coverage, so we don't have to pay so much. That's why we're fighting for it."

Arriaga used to have health insurance through her work, but now that she's unemployed she says she relies more on over-the-counter remedies.

Gerald Kominski, director of the UCLA Center for Health Policy Research, says that's a typical solution for this population. "When people are uninsured they just postpone care-seeking until it's absolutely necessary, and then it's much more costly."

Those working for the Contra Costa program are busy setting up systems to track these new patients.

Potential Savings ... or Costs?

Álvaro Fuentes is director of the county's Community Clinic Consortium, which will provide the medical homes for these new patients. He says they hope to show county officials a year from now that preventive care can save money.

"If we can start with this small set of individuals and are able to start documenting and in some cases capture the cost savings to the health system, it may promote and motivate additional funding," Fuentes says.

But county Supervisor Candace Andersen is not convinced. She voted against the program, which is expected to cost \$1 million and is being paid for by the county and by area hospitals.

"This is a one-year pilot program," Andersen says, "and there's no reliable funding source identified to make sure it's an ongoing program."

Contra Costa County used to provide health care coverage to undocumented adults, but cut its program during the 2009 recession. This move is a small step toward bringing it back.

Gabrielle Lessard, a health policy attorney with the National Immigration Law Center, says the task now is a bit less daunting, because so many more people are insured under the Affordable Care Act.

“Now that the number has been whittled down to a more reasonable level, it’s something the counties can see tackling,” Lessard says. “They understand when one person in a household doesn’t have health insurance, the entire family is one illness or injury away from financial disaster.”

Statewide Support for Coverage

And an increasing number of California voters seem to support tackling the issue. Fifty-eight percent of the state’s voters, according to a recent Field Poll, believe undocumented people should be eligible for Medi-Cal or a similar program.

Anthony Wright is executive director of Health Access, a statewide advocacy group. He believes there is momentum — both policy and political — to extend Medi-Cal to all the state’s undocumented residents. He notes that 48 of California’s 58 counties are now on board to provide some sort of limited low-cost or free health benefits to the undocumented.

“We see the actions by Contra Costa, as well as other counties like Monterey and Sacramento, as county bridges to a statewide solution,” he says.

Wright and his allies recently won a big victory when the state agreed to expand Medi-Cal to cover all undocumented children, beginning next spring. That legislation had included insurance for all undocumented people regardless of age, but was pared down because of cost.

Expense isn’t the only issue for Ira Mehlman, with the Federation for American Immigration Reform, which advocates for stricter immigration policies, including in California.

“California for a long time has been moving in the direction of accommodating illegal immigration, bending over backwards to provide new services and benefits to people in the country illegally,” he says.

Mehlman says other states are watching what’s happening in California — but, he says, it’s a limited number of them.

“If you look at the pattern over the past several years,” he says, “it is pretty much the same states that are doing things that are similar to what California is doing.”

He’s referring to other blue states — like Washington, Illinois, Massachusetts and New York — that already provide health coverage to undocumented children. The District of Columbia provides all its residents with public insurance, regardless of their immigration status.

Then there’s California, with the largest undocumented population in the nation, at 2.5 million. Immigration law advocate Lessard says that makes the Golden State a kind of incubator.

“Advocacy is going to continue,” she says. “It will probably be a multi-year effort, but I think eventually people will come to terms with the fact that everyone is just better off when we all have access to care.”

That advocacy will be felt again in Sacramento next year. A two-year bill that was introduced last December would provide public health insurance to low-income people living here illegally. And the bill, SB10, requests a federal waiver so those with more income can purchase private insurance through the state's health exchange.

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

National Stories

Syphilis, Gonorrhea, Chlamydia Rates Rising for First Time in Years: CDC

Increases are largely driven by STD epidemic among men, U.S. researchers say

Steven Reinberg, HealthDay | 11.17

The number of cases of three key sexually transmitted diseases increased last year for the first time since 2006, concerned U.S. health officials reported Tuesday.

In 2014, 1.4 million cases of chlamydia were reported to the U.S. Centers for Disease Control and Prevention -- a 2.8 percent increase since 2013. This is the highest number of cases of any STD ever reported to the CDC, the government researchers said in the annual report.

Substantial increases were also reported in rates of syphilis (15 percent) and gonorrhea (5 percent). And the syphilis rates were highest among gay and bisexual men, according to the CDC's Sexually Transmitted Disease Surveillance, 2014 report.

"In the previous years, we have had some declines in some diseases and increases in others. But, we are concerned about the alarming increases we are seeing in chlamydia, gonorrhea and syphilis," said lead researcher Dr. Gail Bolan, director of the CDC's Division of STD Prevention.

In 2014, there were just over 350,000 reported cases of gonorrhea -- a rate of nearly 111 per 100,000 people. In addition, there were 20,000 reported cases of syphilis -- a rate of about 6 per 100,000, the report said.

STDs affect young people and women most severely. However, increasing rates among men represent a large part of the overall increases across all three STDs, Bolan said.

"We are concerned that most of the surging rates are among men," Bolan said. "Men are driving these increases. There is an urgent need to tackle the increases we are seeing."

Syphilis among gay and bisexual men has been increasing since 2000, she said. In 2014, these men accounted for 83 percent of reported cases among men when the sex of the partner is known. And just over half of men with syphilis in 2014 were also HIV-positive, Bolan added.

There is also evidence that gay and bisexual men are seeing similar increases in gonorrhea and chlamydia, she said.

Despite that, young people are still the most disproportionately affected by STDs, Bolan added. Last year, those between the ages of 15 and 24 accounted for nearly two-thirds of the reported cases of chlamydia and gonorrhea. That compares to previous estimates that young people get half of the estimated 20 million new STDs diagnosed each year in the United States, she pointed out.

While STDs are preventable and treatable, Bolan suggested that diminished access to clinics has contributed to the increased epidemic in recent years.

"About 7 percent of health departments have closed STD clinics," Bolan said. "Over 40 percent have reduced clinic hours, and clinics have increased fees and co-pays. We are concerned that people are not getting access to the STD health services they deserve and need," she said.

Fred Wyand, a spokesman for the American Sexual Health Association, agreed with her assessment. "One key finding is the worrisome and continuing trend of health disparities," he said.

The most vulnerable populations, particularly young people, women and gay and bisexual men, continue to be hardest hit, Wyand said.

"We know many factors are behind these alarming increases: mass incarceration, poverty, stigma, homophobia," Wyand said. "Add to that the fact that the best STD control programs we develop are limited by a complex array of issues, including stable housing, transportation to clinics, and leave time from work."

And, he added, "young people are more biologically susceptible to STDs and also often lack health insurance or the empowerment necessary to effectively navigate the health care system."

A crucial part of the solution to the rising rates is STD prevention messages that highlight condom use along with greater access to testing and treatment, Wyand said.

Also, given that the annual cost of STDs is \$16 billion, he said, policy makers should be told that prevention programs are not only sound health policy, but they also save money.

More information

For more on STDs, visit the [U.S. Centers for Disease Control and Prevention](#).

SOURCES: Gail Bolan, M.D., director, Division of STD Prevention, U.S. Centers for Disease Control and Prevention; Fred Wyand, spokesman, American Sexual Health Association; Nov. 17, 2015, U.S. Centers for Disease Control and Prevention report, *Sexually Transmitted Disease Surveillance, 2014*

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

More Babies In The U.S. Are Dying Because Of Congenital Syphilis

Angus Chen, NPR | 11.13

The number of babies born with syphilis has shot up, and it's taking a toll.

Of the 458 babies born last year with syphilis, 33 were stillborn or died shortly after birth. From 2012 to 2014, there's been a 38 percent increase in cases of congenital syphilis in the U.S. The spike reverses a previously falling trend in the rates of babies with syphilis from 2008 to 2012, according to a [report](#) released Thursday in *Morbidity and Mortality Weekly Report*.

As rates of new syphilis infections rise and fall, rates of fetal and congenital syphilis tend to follow suit, says Virginia Bowen, an epidemiologist at the Centers for Disease Control and Prevention and lead author on the study. If a pregnant woman carries the bacteria, syphilis can infect the unborn fetus. When that happens, a lot of things can go awry.

"Up to 40 percent of babies will die in utero or shortly after delivery," Bowen says. "Or they might have severe illness like blindness or deafness or other types of damage."

It's hard to know the reason behind the recent surge in syphilis cases, Bowen says. "The only thing I can say is syphilis is going up right now across the board," she says. "From '13 to '14, we are seeing syphilis going up everywhere, including among the women, and we don't have the answers as to why."

The rising rates in congenital syphilis might betray a larger problem among health care for women and pregnant women, Bowen says. "There are a lot of barriers to getting into the door at the prenatal care provider. That could be related to insurance status, stigma or discrimination." If women aren't getting adequate prenatal care, then they can't be screened for syphilis.

Access to care can be particularly hard for certain populations, says Dr. Martha Rac, a maternal-fetal medicine physician at Ben Taub Hospital and Baylor College of Medicine in Houston who was not involved with the study.

"African-American women are more disproportionately affected by syphilis than any other race," she says. And 57 percent of children with congenital syphilis were born to African-American women.

Lack of prenatal care is probably the greatest contributor to the upturn in congenital syphilis, Rac says. "It seems to be the common theme that women having congenitally infected babies overwhelmingly have, if any, late, poor prenatal care. That is a big area which can be targeted from a public health standpoint."

Some states have been harder-hit than others. California went from 35 cases in 2012 to 99 in 2014, while Texas continued to see a slight decline in the overall number of babies born with syphilis. "In April, I designated Fresno County as an area of high syphilis, so providers are required to screen for syphilis three times during pregnancy," says Dr. Ken Bird, health officer for the Fresno County Department of Public Health.

There are states that have free health coverage for pregnant women. "In California, every pregnant female has coverage for prenatal care [through the Medi-Cal program]. Many don't realize that, and they're not sure how to access that care," Bird says. Other states may cover prenatal visits through state Children's Health Insurance Programs.

Syphilis is a difficult disease to diagnose, Bowen says. Many people become asymptomatic after the first lesions or rashes appear, but can still pass the infection on to their unborn children. But as long as the

infection is caught early enough, a simple course of antibiotics is enough to ensure a healthy baby. "Of the 458 cases we had last year, every single one of them is considered preventable," she says.

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

Use of Long-Acting Birth Control Methods Surges Among U.S. Women

Sabrina Tavernise, The New York Times | 11.10

The share of American women on birth control who use long-acting reversible methods like intrauterine devices and implants has nearly doubled in recent years, the federal government reported Tuesday.

The share of women on birth control who use the devices rose to 11.6 percent in the period from 2011 to 2013, up from 6 percent in 2006 to 2010, according to the National Center for Health Statistics. The share is still smaller than for the pill (26 percent) or condoms (15 percent), but it is the fastest-growing method. In 2002, just 2.4 percent of women on birth control in the United States used the long-acting methods.

Women's health advocates say long-acting birth control is giving American women more say over when — and with whom — they have children. About half of the 6.6 million pregnancies a year in the United States are unintended, and health experts contend that broader use of long-acting methods could help reduce that number, because the methods work better than other types.

The methods are effective because, unlike the pill, a diaphragm or condoms, they do not require a woman to take action to work. Although an early incarnation, the Dalkon Shield, introduced in the 1970s, had disastrous results, the modern devices are safe and have been increasingly promoted by doctors. Last fall, the American Academy of Pediatrics published guidelines that for the first time singled them out as a "first-line" birth control option for adolescents, citing their "efficacy, safety and ease of use."

About 62 percent of women in the United States use birth control, according to the report, which draws on data from a nationally representative federal survey.

The use of long-acting birth control was driven by a surge in the use of intrauterine devices. About 10.3 percent of women on birth control reported using those devices in 2011 to 2013, and about 1.3 percent used implants.

Use was roughly the same across educational groups, the report found. Use of long-acting methods was lower among black women. About 8.6 percent of black women used long-acting methods, compared with 15.1 percent of Hispanics and 11.4 percent of whites.

Female sterilization, the second most popular method after the pill and used by about a quarter of all women on birth control, was far more common among women with less education. About 40 percent of women with just a high school diploma or the equivalent used that method, compared with about 15 percent of women with a bachelor's degree or higher. In contrast, the pill was used by about a third of women with a college degree or more but by just 13 percent of women with a high school degree or less.

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

Researchers develop one-step urine test for screening HCV

Melinda Stevens, Healio Hepatology | 11.14

Researchers from University of California Irvine have developed a one-step urine-based test effective for screening and diagnosing hepatitis C virus infection that may reduce costs, according to a poster presentation at The Liver Meeting 2015.

“Our novel HCV antigen test system has significantly improved sensitivity and specificity over current tests,” Ke-Qin Hu, MD, director, hepatology services, H.H. Chao Comprehensive Digestive Disease Center School of Medicine, University of California Irvine, said in a press release. “Importantly, for the first time, we can use urine specimens for one-step screening and diagnosing of HCV infection. Finding a more convenient, easy-to-use and cost-effective screening alternative is imperative, because HCV is significantly underscreened and under-diagnosed.”

Using their novel test system, HCV-Ags EIA assay, developed for one-step screening and diagnosing of viremic HCV infection, Hu and his colleague Wei Cui, MD, analyzed urine samples from 128 patients without renal disease and 27 patients with chronic kidney diseases, to determine if the test results were consistent with serum HCV RNA PCR, the current standard test to confirm viremic HCV infection.

Among 35 urine samples from 20 patients without HCV and 15 patients with resolved HCV, the researchers observed a 100% concordance with serum HCV RNA PCR results, ie, 100% specificity of the HCV-Ags EIA for viremic HCV infection.

In 93 urine samples from patients with HCV, the HCV-Ags EIA assay showed a 100% sensitivity rate for detecting active or viremic infection. This was not affected by renal dysfunction or hemodialysis, according to the abstract.

After urine samples were diluted, the lowest detection limit of the HCV-Ags EIA assay was equivalent to HCV RNA at approximately 50 IU/mL. In addition, the optical density measurements of the urine samples from the HCV-Ags EIA test were correlated to the corresponding serum HCV RNA load.

According to the release, current blood-based HCV tests require two steps and can cost more than \$200 in the U.S.

“The ability to detect infection using urine rather than blood avoids needle stick and blood sample collection, greatly reduces the cost and necessary clinical infrastructure for screening and diagnosis, helping to promote widespread adoption of the test on a global scale,” Hu said.

The researchers concluded: “The present study demonstrates for the first time that HCV-Ags can be reliably detected in urine specimens as a one-step diagnostic test for all HCV genotype infections. Our HCV-Ags EIA eliminates the need for a blood specimen, establishes a diagnosis of active HCV infection in a single, noninvasive step, and would increase the capacity of global screening for pangenotypic infections more cost-effectively.”

Hu noted that the technology has now been licensed to DiligenMed Inc.

Reference:

Hu K-Q, et al. Abstract 1785. Presented at: The Liver Meeting; Nov. 13-17, 2015; San Francisco.

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

Hepatitis C May Transmit Sexually From Rectum Without Blood

As reported by POZ.com | 11.17

Men may acquire hepatitis C virus (HCV) sexually from the rectums of HIV/HCV-coinfected men even when there is no blood present, HIVandHepatitis.com reports. Researchers took rectal fluid samples from 45 coinfected men who have sex with men (MSM), 12 of whom were acutely infected. They presented their findings at the Annual Meeting of the American Association for the Study of Liver Diseases (AASLD) in San Francisco.

The 21st century has seen an emerging epidemic of sexually transmitted hep C among MSM, particularly those living with HIV, in Europe, North America and Australia.

The investigators of this new study also measured the participants' hep C viral loads, and tested them for rectal sexually transmitted infections (STIs) and syphilis.

Twenty of the 45 samples (47 percent) had detectable hep C. (Two samples could not be processed.) There was a strong correlation between the viral load in the rectal fluid and in the blood; those participants who had a high blood viral load were much more likely to have detectable virus in their rectal fluid.

The researchers found no correlation between the detectability of hep C in the rectal fluid and whether the men were acutely or chronically infected, or whether they had rectal STIs or syphilis.

The researchers concluded that the levels of hep C found in the rectal fluid would be sufficient for transmission of the virus during anal sex. Other sexual activities that may facilitate hep C transmission without blood include group sex, the use of sex toys, fisting, or through the use of anorectal douching equipment.

Another study presented at the meeting analyzed stool samples from 98 men and women monoinfected with hep C. The investigators found that 68 samples (69 percent) had detectable hep C, with blood only present in five of those samples. Eighty-three percent of the samples from the men had detectable virus, compared with 52 percent of the samples of the women.

To read the HIVandHepatitis article, [click here](#).

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

Gay Dating Apps Are Leading The Way On Safer Sex

Pressure is mounting for Tinder and its ilk to address STIs, but apps like Scruff already have

Tracy Clark-Flory, vocative | 11.7

Last fall in San Francisco, representatives from Grindr and several other gay dating apps sat down at a conference table with leading public health officials. The matter at hand: figuring out what dating apps could do to encourage safer sex. They talked about connecting users to STI testing, offering partner notification services and creating “stigma-free” HIV communities. It was a groundbreaking summit, the very first of its kind, and it garnered zero mainstream media attention.

The same cannot be said for the recent alarm about dating apps and STI rates. Much digital ink was spilled this past week about a doctor from the British Association for Sexual Health warning that dating apps could cause an “explosion” of HIV and arguing that companies like OKCupid “have to invest more time in pushing a safe sex message.” Earlier this fall, the AIDS Healthcare Foundation launched a billboard campaign implying that companies like Tinder and Grindr are breeding grounds for STIs. In May, health officials in Rhode Island and Utah linked growing infection rates with the popularity of, yep, you guessed it.

Lost in the media coverage, which invariably focuses on the world of hetero romance, is the fact that gay dating apps and websites are beginning to innovate around STI prevention.

“There’s a lot of cool things that the technology allows and we’re just starting to do that,” says Sean Howell, CEO of Hornet. Hornet, a dating app aimed at gay men, encourages users to share their HIV status in their profiles and gives special badges to those who do. It also connects people to their closest STI testing center, in some cases allowing people to make appointments, and offers personalized reminders to get re-tested. Hornet, which says it has 7 million users worldwide, has even scheduled mobile test clinics in places like the Philippines, where the number of HIV cases has risen by 277 percent in the last five years. Hornet has also helped source participants for clinical trials around herpes and HPV; and when there was a gonorrhea outbreak in Los Angeles a couple years ago, they sent announcements to their users about symptoms and how to get tested.

Several of these are things that other gay dating apps have incorporated in one way or another. Scruff last year launched BenevolAds, a free service allowing non-profits and state agencies working within the LGBT community—including around safer sex—to create and publish targeted banner ad campaigns. The app recently added the option for users to indicate whether they use condoms or use Pre-Exposure Prophylaxis (PrEP), a pill taken to prevent HIV. Daddyhunt encourages users to talk about their “sexual health plans” and asks them to sign a code of values affirming the importance of “protect[ing] themselves and their partners, emotionally and physically.” The company also just launched hashtags in the app, which it plans to use to foster conversations related to sexual health.

“My general philosophy has always been that it’s much more important to have as much conversation about STIs, and about HIV in particular in the gay community, prior to the very complicated act of intimacy,” says Carl Sandler, CEO of Daddyhunt. “So, as much as you can invite people to share openly, and feel comfortable sharing their status openly, that’s been something that we’ve tried to encourage.”

Two major studies have highlighted the issue of STIs and dating apps. Last year, a Los Angeles study found that men who used apps to meet other men for sex were more likely to have sex without condoms, to have more partners and to have STIs than those who found partners in more traditional venues, like a bar. Critics have argued that the study’s choice of subjects—visitors to an STI clinic—could have skewed the results.) An earlier study looked at the introduction of personal ads on Craigslist and the incidence of HIV and concluded that it was “related to a 15.9 percent increase in HIV cases.”

“Sites and apps can make for a very efficient sexual marketplace, it can be simply easier to find a partner. If there’s somebody online who’s having a lot of partners and is infected with syphilis, if they’re being really efficient about finding partners, it’ll also be really efficient for syphilis to get transmitted,” says Dan Wohlfeiler, a researcher at the University of California, San Francisco who helped facilitate the STI summit last year.

But some question the nature of the link between STIs and apps. “There is no evidence that phone apps cause an increase in STIs,” Cary James, head of programs at the Terrence Higgins Trust, a British HIV charity, wrote in an email. “There are some studies that report that people who use phone apps are most likely to have an STI, but that’s a much different thing. It is not the apps themselves but the behavior of the people using the apps when they meet people which can put them at risk of STIs.”

There is no question that STIs are on the rise among men who have sex with men (MSM). The rate of new HIV diagnoses has gone down in the population at large, while it’s gone up significantly among MSM. Syphilis is another major issue: In 2013, MSM accounted for 75 percent of such cases in the U.S.

That, and the gay community’s historical struggle with HIV and AIDS, might partially explain why exclusively MSM apps have taken to prevention efforts while straight outlets largely have not. Howell says gay dating apps tend to have a smaller, more community feel. “Being a smaller company you get to take risks,” he says. “When you become a big company you get conservative.”

The recent media attention could push these awareness-raising efforts beyond the world of exclusively MSM dating. Only one company of four Vocativ contacted responded to requests for comment. “I personally think that dating apps should not be blamed and therefore should not carry the obligation to do STI prevention, which is a public health responsibility,” Marie Cosnard of that company, Happn, wrote in an email. She added, though, that her company is “currently thinking about ways to send out safe-sex messaging to our users.”

Happn isn’t alone. Ramin Bastani, CEO of Healthvana, an app that allows users to receive electronic STI test results, tells me that mainstream dating apps have recently begun reaching out to his company about potential partnerships to address this issue—just as media attention around the topic has heated up. “I think there’s a general understanding among the people who run those companies that there may be additional things they can do to help,” he says. That includes incorporating a testing clinic locator or allowing people to unlock their most recent test results for particular romantic interests.

Luckily, if these mainstream apps decide to go down this path, they will have gay apps already leading the way. The Building Healthy Communities Project, which organized the meeting last year, conducted a study to determine the best approaches for STI prevention on dating apps. Researchers surveyed owners of gay dating apps and websites, users of those services and public health officials and came up with a list of initiatives that the majority of those groups gave the thumbs up. That included referrals to testing sites, testing reminders, partner notification services and the option to express a preference for safe sex in your profile, as well as several other relatively simple features.

“The same basic principles that we’re using for the sites that gay and bi men use, they can also apply to the Tinders of the world,” says Wohlfeiler. “Clearly, they can have a profound impact for public health—either to facilitate the transmission of STDs, including HIV, across whole populations or to play an incredibly important role with prevention.”

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

Scientific Papers/Conference Abstracts

Exploring Contextual Factors of Youth Homelessness And Sexual Risk Behaviors: A Qualitative Study

Santa Maria D, Narendorf SC, Ha Y, et al. *Perspectives on Sexual and Reproductive Health* 2015;47(4): TK, doi: 10.1363/47e6715

CONTEXT:

HIV disproportionately affects homeless youth, and interventions to date have had minimal success in reducing sexual risk behaviors in this population. Few qualitative studies have been conducted to provide insight into the influence of homelessness-related factors on sexual risk behaviors.

METHODS:

A qualitative study with a quantitative component was conducted with a nonprobability sample of 64 homeless youth aged 14–24; participants were recruited from a variety of venues in Houston between October 2013 and March 2014. Thirteen focus group discussions were conducted; thematic analysis was used to identify themes related to HIV risk.

RESULTS:

Participants were predominantly black (75%), sheltered (67%) and aged 18 or older (77%). Youth discussed how the circumstances of their homelessness and the struggle to meet their immediate needs led to behaviors and experiences that put them at risk for HIV. Three themes emerged: Homeless youth frequently engage in risky sexual behavior, sometimes as a way to cope with stress; they often trade sex, either voluntarily or involuntarily, for such necessities as money or a place to sleep; and many experienced childhood sexual victimization or have been victimized since becoming homeless. Youth also described how stress, stigma and self-reliance contributed to their involvement in HIV risk behaviors.

CONCLUSIONS:

HIV prevention methods that target stress and stigma while respecting youths' self-reliance may help reduce sexual risk behaviors. Further research is needed to determine suitable behavioral change techniques to address these potentially modifiable factors.

View the paper online: [Abstract](#)

Opportunities and Challenges of Digital Technology for HIV Treatment and Prevention

Simoni JM Kutner BA, Horvath KJ. *Current HIV/AIDS Reports* 2015;12(4):437-440

Abstract:

Novel eHealth interventions are creating exciting opportunities for health promotion along the continuum of HIV care and prevention. Reviews of recent work indicate the use of multiple platforms (e.g., smartphones, social media), with trends toward individualized approaches and real-time assessments. However, the field needs more rigorous investigations to provide evidence of long-term impact on clinical indicators and should expand its targets beyond men who have sex with men and medication adherence. Challenges to the field include working within restricted funding timelines and disseminating eHealth interventions to those most in need.

To view the full Topical Collection on HIV and Technology in this issue of Current HIV/AIDS Reports: [Click here](#)

View the paper online: [Abstract](#)

Unknown Human Immunodeficiency Virus Status and Associated Risk Factors among Pregnant Women in the United States: Findings from the 2013 Behavior Risk Factors Surveillance System

Dehghanifirouzabadi A, Qobadi M. *J AIDS Clin Res* 2015;6:516

Background:

Although prenatal Human Immunodeficiency Virus (HIV) infections are declining in the United States, many women of child bearing age are unaware of their HIV status. HIV testing before or during the early stages of pregnancy is a critical first step to reduce the risk of mother-to-child transmission.

Objective:

The aim of this study was to estimate prevalence of women with unknown HIV status and to explore the associations between socio-demographic characteristics, health care access and HIV testing among pregnant women in the United States.

Methodology:

Data from the 2013 Behavior Risk Factors Surveillance System (BRFSS) were used to calculate estimates of HIV testing prevalence among pregnant women in the United States (n=2,722). Pregnant women who never had an HIV test or had not been tested for HIV within the past year were considered as pregnant women with unknown HIV status. Descriptive statistics, Chi-square tests and logistic regression were done using SAS Proc Survey procedures, to account for BRFSS's multistage complex survey design and sample weights.

Results:

Overall, 30.3% of pregnant women had never been tested for HIV and among these women, only 24% had past-year HIV testing. Non-Hispanic whites ($p<0.0001$), those aged 18-24 years ($p=0.02$), married women ($p=0.02$), those with no insurance ($p<0.001$) and no personal doctor ($p=0.02$) had significantly higher rates of no lifetime HIV testing. Pregnant women aged 35-44 years (39.2%), those with annual income of \$50,000 or more (32.9%) and those who were married (31.4%) had significantly higher rate of no past-year HIV testing. Multiple logistic regressions showed that the likelihood of having never been tested for HIV was greater among non-Hispanic whites (aOR=2.1; 95% CI:1.3– 3.4; reference=other races), married women (aOR=1.7; 95% CI:1.1–2.3; reference=unmarried), those aged 18-24 years (aOR=2.1; 95% CI:1.4–3.3; reference=35 years old or more), and those who had no insurance (aOR=2.2; 95% CI: 1.3–3.7; reference=covered by insurance). Among those who ever had an HIV test, married

women were two times more likely to have no past-year HIV testing than unmarried women (aOR=2.0; 95% CI:1.3–3.1; reference=unmarried); while, younger women (18-24 years old) were less likely to have no past-year HIV testing (aOR=0.3; 95% CI: 0.2–0.7 reference=35-44 years old).

Conclusion:

Our findings indicated that prevalence of unknown HIV status (lifetime and recent) was high, raising concerns about the prenatal HIV testing approaches in the United States. The likelihood of having never been tested for HIV was greater among non-Hispanic whites, married and younger (18-24 years old) women, and those who had no insurance after controlling for covariates. In addition, the results showed that married women had higher likelihood of having no recent HIV test; while, younger women (18-24 years old) were less likely to have no past-year HIV testing. Our findings highlight the need to continue and strengthen efforts to prevent perinatal HIV transmission in the United States through increasing HIV testing awareness. Health care providers should recommend HIV testing to all women of childbearing age, regardless of sociodemographic characteristics to reduce this mode of transmission.

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

HIV Disparities in a US and Foreign-Born Cohort in Urban United States

Kwakwa HA, Wahome R, Bessias S. *J AIDS Clin Res* 2015;6:515

Background:

As we strive to reduce disparities in the implementation of the US National HIV/AIDS Strategy, we must understand HIV disparities as they exist in all US populations, including the foreign-born. We evaluate disparities in HIV prevalence in a US and foreign-born cohort in Philadelphia.

Methods:

Comparative analyses were conducted using data from questionnaires paired with HIV test results for individuals undergoing HIV testing in Philadelphia between 2007 and 2011. Descriptive analyses were conducted by gender and world region of origin.

Results:

Of 14,216 participants, 76.2% were US-born and 59% female. Caribbean men, 3.6% of the cohort, constituted 11.4% of the HIV- positive. Among women, Africans, 3.0% of the cohort constituted 4.5% of the HIVpositive. No disparities by race/ethnicity were found in the US-born cohort.

Conclusions:

In this global population in Philadelphia, HIV disparities were found to occur by world region of birth and gender. The foreign-born must be included in analyses of the domestic epidemic that drive prevention strategies, policy and resource allocation

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

Resources, Webinars, & Announcements

New Guidance on Hepatitis C Drugs Released

AIDS United

The Centers for Medicare and Medicaid Services (CMS) last week released [new guidance](#) advising States on the utilization review practices for the coverage of drugs for Medicaid beneficiaries living with hepatitis C virus (HCV) infections. The guidance makes three main points clear:

- States must cover the new direct-acting antiviral (DAA) drugs used in HCV treatment since they are covered under rebate agreements entered into by the manufacturers,
- States may not unreasonably restrict access to these drugs, and
- Medicaid Managed Care Organizations (MCOs) used by states may not implement more restrictive coverage rules for HCV medications than other Medicaid services.

Moreover, CMS provides specific examples of unreasonable limitations, including limiting treatment to beneficiaries whose extent of liver damage has progressed to metavir fibrosis score F3; requiring a period of abstinence from drug and alcohol abuse; or requiring prescriptions to be prescribed by specific providers such as gastroenterologists, hepatologists, liver transplant specialists, or infectious disease specialists. CMS states that “such limitations should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections,” and that “States should, therefore, examine their drug benefits to ensure that limitations do not unreasonably restrict coverage of effective treatment.” CMS urged states to carefully monitor the DAA HCV drug coverage policies of MCOs.

CMS also noted that manufacturers should also seek to ensure access and affordability for the DAA medications sending individual [letters to manufacturers](#) asking them to provide information regarding value-based purchasing arrangements they offer for these drugs so that states might be able to participate in such arrangements.

Partially in response to these developments, The Hepatitis Education Project drafted a [template letter/white paper](#) for people to reach out directly to State Insurance Commissioners to remove illegal restrictions to access to hepatitis C treatment.

Unfortunately, Medicaid Health Plans of America CEO, Jeff Myers, responded to the guidance by stating that it made sense to bar heavy alcohol users from access to hepatitis [C] drugs on the grounds that their livers could counteract the drugs’ effectiveness – a statement contrary to [current HCV treatment guidelines](#). He also said that people who inject drugs might not have the “mental capability to complete a full course of hepatitis treatment.” Again, this is flatly false and contravened by research. Given that these plans play a strong role in providing care to people with hepatitis C, AIDS United calls on Mr. Myers to rescind his statements and ensure that such all Medicaid health plans come into compliance with the new guidance.

For more information: [Click here](#)

REPORT: HIV Surveillance Supplemental Report, CDC

CDC

HIV Surveillance Supplemental Report: [Social Determinants of Health among Adults with Diagnosed HIV Infection in 11 States, the District of Columbia, and Puerto Rico, 2013](#)

HIV Surveillance Supplemental Report: [Social Determinants of Health among Adults with Diagnosed HIV Infection in 11 States, the District of Columbia, and Puerto Rico, 2013](#)

A new HIV Surveillance Supplemental Report focuses on census tract-level social determinants of health (SDH) among adults with HIV infection diagnosed in 2013 in 11 U.S. states, the District of Columbia, and Puerto Rico. The SDH variables examined are: percentage of the population living below federal poverty, percentage of the population with less than a high school diploma, median household income, percentage of the population unemployed, and new to this report, percentage of residents without health insurance coverage. This report presents a snapshot of the environment in which people lived at the time of HIV diagnosis.

HIV Surveillance Supplemental Report: [HIV/AIDS data through December 2013 provided for the Ryan White HIV/AIDS Program, for fiscal year 2015](#). Revised edition.

The report displays data used for funding allocations among various categories of grantees under the Ryan White HIV/AIDS Program, for Fiscal Year 2015.

Updates from CDC's Division of STD Prevention – Congenital Syphilis

If you haven't visited <http://www.cdc.gov/std/> in a while you should stop by to see our redesigned website! The updated website includes new navigation, a new look, and is now easily accessible on all devices.

Last week, the U.S. Centers for Disease Control and Prevention (CDC) published "[Increase in Incidence of Congenital Syphilis — United States, 2012–2014](#)," in the *Morbidity and Mortality Weekly Report*. The analysis shows that after years of decline, the number of congenital syphilis cases reported in the United States increased between 2012 and 2014. More information about the report and ways to prevent this needless tragedy can be found in a [Dear Colleague Letter](#) from Dr. Gail Bolan, Director of the CDC's Division of STD Prevention. General information about the topic can be found in the new [congenital syphilis fact sheet](#).

The annual STD Surveillance Report was released this afternoon. Data in [Sexually Transmitted Disease Surveillance 2014](#), show that cases of all three nationally notifiable sexually transmitted diseases—chlamydia, gonorrhea, and syphilis—have increased for the first time since 2006. As partners in this effort, CDC has developed several resources to help you better understand the issue and share prevention messages in your community, including a

- [2014 STD Surveillance Report Fact Sheet](#),
 - [Fact Sheets about STDs](#), and
 - [Posters, stickers, and other free STD prevention campaign materials](#).
-

New factsheet: HIV treatment and recreational drugs

When two drugs are taken at the same time, their interaction can affect the drugs' effectiveness and side-effects.

This is the case both for prescribed medicines and recreational drugs, although there is much less medical research on drug interactions with illicit drugs. But we do know that some anti-HIV drugs and some recreational drugs are metabolised (processed) by the same pathways in the body. This can alter the effect of one or both drugs when they are combined.

This applies to some, but not all anti-HIV drugs. Similarly it only affects some recreational drugs.

Nonetheless, recreational drugs are rarely sold in a pure form, so it is hard to know what they contain. They may have been 'cut' with other substances and may contain larger or smaller quantities of the active ingredient than expected. Predicting how recreational drugs will interact with HIV medications is not straightforward.

View and download the fact sheet: [Click here](#)

WEBINAR: Expanding HIV Prevention for Women: Integrating PrEP into Family Planning Health Centers

CFHC

DATE: Dec. 16

TIME: 12:00 – 1:00 PM PST

Presenters:

Risa Hoffman, MD, Assistant Clinical Professor, Division of Infectious Disease, David Geffen School of Medicine, UCLA

Janie Caplan, MD, Clinical Research Fellow, Division of Infectious Disease, David Geffen School of Medicine, UCLA

Overview:

Truvada™ is now approved for HIV prevention. However, marketing campaigns, community outreach and clinical training about this important new tool have focused primarily on men. Family planning providers are uniquely positioned to integrate the provision of Truvada™ into existing reproductive health and STD prevention services. This session will explore some of the emerging data on the potential to help female patients reduce their risk of contracting HIV.

What Will You Learn?

After attending this training, participants will be able to:

- Identify women who would be good candidates for PrEP
- Counsel women about safety and efficacy based on the current clinical evidence of Pre-Exposure Prophylaxis (PrEP) in women
- Implement the use of Pre-Exposure Prophylaxis (PrEP) as recommended in individuals who are at-risk for HIV (based on CDC guidelines)

Who Should Attend?

- Physicians
- Clinicians
- Nurses
- Clinic Administrators
- Medical Directors
- Family Planning Staff
- Medical Assistants
- Health Educators + Counselors

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

For more information: [Click here](#)

Job/Internship Postings

Statistician – CDPH STD Control Branch

Organization: CDPH STD Control Branch

Location: Richmond, CA

JOB OVERVIEW

The Department of Obstetrics, Gynecology and Reproductive Sciences (Ob/Gyn & RS), SFGH Division is seeking a Statistician for its Sexually Transmitted Diseases (STD) Branch contract. This position is assigned to the California Department of Public Health (CDPH), Sexually Transmitted Diseases Control Branch (STDCB) and is under the direction of the Office of Viral Hepatitis Prevention (OVHP) Chief.

Under the general direction of the Viral Hepatitis Prevention Coordinator at the CDPH, STDCB, OVHP, this position leads data collection and quality assurance, data analysis, and program evaluation and findings dissemination for state-funded, hepatitis C screening and linkages to care demonstration projects in public health, safety net, and community-based settings. Results of analyses are presented to diverse audiences in a range of formats, and will require development of innovative analyses and reporting systems. This position is dependent on the availability of state general funds.

REQUIRED QUALIFICATIONS

- BA/BS degree with a major in statistics or a related field and two years of professional statistical experience; or an equivalent combination of education and experience; and knowledges and abilities essential to the successful performance of the duties assigned to the position.
- Expertise in data analysis and database management (SAS proficiency and expertise in Microsoft Access or related statistical or database management software)
- Ability to communicate effectively (verbally and in writing)
- Ability to collaborate with a multi-disciplinary group of health professionals
- Ability to manage and prioritize multiple tasks and projects and to work independently

This position may also be viewed at: <http://ucsfhr.ucsf.edu/careers/>

Search openings- requisition #: 43769BR

Lead Program Analyst, HIV/STI/Hepatitis & Healthcare Integration – NACCHO

Organization: The National Association of County and City Health Officials (NACCHO)

Salary: \$77,981 – \$81,100

The National Association of County and City Health Officials (NACCHO), a national organization representing approximately 2,800 local health departments (LHDs) nationwide, has an immediate opening for full-time Lead Program Analyst.

POSITION SUMMARY

A Lead Analyst is considered a subject matter expert with advanced knowledge and experience in an area of specialization. Lead Analysts work on complex projects and provide strategic guidance and direction to NACCHO in their areas of expertise. Lead Analysts must have strong analytical, research, and writing skills and the ability to interface with the highest level of internal and external stakeholders.

This position reports to the Director of the HIV, STI, and Viral Hepatitis program.

Program Specific Information NACCHO's HIV, STI, and Viral Hepatitis program aims to strengthen the capacity of local health departments to prevent, control, and manage HIV, STIs, and viral hepatitis by providing technical and capacity building assistance, developing and disseminating tools and resources, and facilitating information exchange, peer engagement, and learning. The program contributes to NACCHO's overall mission to be a leader, partner, catalyst, and voice for local health departments and supports NACCHO's work to advocate on behalf of local health departments with federal policymakers for adequate resources, appropriate public health legislation, and sensible policies to address the myriad of challenges facing communities.

The Lead Analyst for HIV/STI/Hepatitis & Healthcare Integration will be responsible for leading project activities that explore, support, and advance local health department program efforts to effectively and appropriately adapt their HIV, STI, and hepatitis programs to changes in the public health and healthcare systems resulting from the implementation of the Affordable Care Act (ACA). The position will explore the intersection of local health department programs with the healthcare system, help to articulate the role of local health departments across prevention and care continuums, and assess new and evolving financing and payment models for public health and healthcare services. The Lead Analyst will serve as a liaison between the HIV, STI, and Viral Hepatitis program and NACCHO's Public Health Transformation program.

As a member of NACCHO's overall Infectious Disease team, the Lead Analyst will have the opportunity to provide strategic direction and support to program areas across the team and will be required to look for opportunities across all NACCHO program areas to support, expand, and leverage NACCHO's HIV, STI, and Viral Hepatitis activities.

The ideal candidate will have advanced expertise related to public health and healthcare systems and the drivers of integration resulting from the ACA; the implications of healthcare reform and systems integration on local health department HIV, STI, and viral hepatitis programs; health insurance and payment models; HIV, STI, and viral hepatitis prevention and care; and related health policy.

POSITION SPECIFIC DUTIES

- Uses content knowledge and skills to develop, implement, monitor, evaluate, and promote programmatic work.
- Maintains situational awareness of research, policies, and practices relevant to designated area of work.
- Conducts research and assessment activities and develops reports to share project activities and findings.
- Conducts policy analysis and writes NACCHO policy statements and organizational responses to federal actions.
- Collaborates with other staff, NACCHO members, and external partners in developing internal and external publications, including peer-reviewed journal articles, educational materials and other public health tools, project summaries, and research briefs.
- Develops and delivers presentations, scientific posters, and exhibits to share and promote project findings at professional and public meetings and conferences.
- Provides technical and capacity building assistance to local health departments and other partners and stakeholders at the local, state, national, and federal levels.
- Contributes to long-term project planning, including identifying future activities and searching and applying for additional funding to support designated area of work.
- Contributes to continuation and competitive grant proposals for their designated specialty area of work.
- Represents NACCHO at national, state, and local meetings, conferences, and other public events on issues related to designated area of work.
- Liaises with other national organizations, industry, and federal, state, and local partners, as appropriate.

Unit/Program Specific Duties

- Assesses and explores local health department goals, opportunities, threats, needs, and strategies associated with HIV, STI, and viral hepatitis policy and practice within the context of evolving public health and healthcare systems.
- Analyzes healthcare integration efforts across the HIV, STI, and viral hepatitis prevention and care continuums at the local and state level and determines the drivers for success.
- Identifies, develops, tests, evaluates, and refines models and tools to support public health and healthcare systems integration related to HIV, STI, and viral hepatitis prevention and care services.
- Supports local health department adoption and implementation of related evidence-based and evidence-informed policies and practices.

EDUCATION/EXPERIENCE/SKILLS

Doctoral degree or equivalent with a minimum of four years of work experience or a Master's degree with a minimum of six years of work experience preferred. Equivalent combination of education and experience, including relevant certifications will be considered.

JOB CLASSIFICATION: Full-time, Exempt, **TERM:** This position is considered a term position made possible through grant funding, some or all of which is scheduled to end July 31, 2016. While NACCHO will make every effort to secure continued funding, this position may be eliminated on July 31, 2016.

HIRING SALARY RANGE: \$77,981 – \$81,100

SELECTION PROCESS: We only accept applications that follow the electronic process. No phone calls please. This position is subject to background screening. Qualified applicants should send a cover letter, resume, one writing sample with salary requirements to: PN-296 Lead Program Analyst – HIV/STI/Hepatitis & Healthcare Integration using the following link: <https://naccho.clearcompany.com/careers/jobs/21c0b27f-349a-9d9e-64eb-dbe5c7cc54be/apply?source=313360-CS-2909> NACCHO offers generous benefits plan including but not limited to 13 days of sick leave annual leave allowable accumulation up to 225 hours, and paid vacation leave, as well as other types of leave. NACCHO benefits include a generous health, dental, and vision

plan, 5 percent of base salary contribution to 403(b) plan, (not a matching contribution); paid short and long term disability plan and paid term life insurance. NACCHO also offers discounted gym membership.

At NACCHO, our commitment to equal employment opportunity and affirmative action seeks to ensure a work environment free of discrimination and harassment. We respect and value work force diversity among all employees and all those with whom we do business.

Internal Number: PN 296

For more information: [Click here](#)

Aaron Kavanaugh

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STD Control Branch, California Department of Public Health
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