

[STD Update] FYI 3-2: CA's new sex ed requirements, Newly diagnosed men often 'hooked up' online, Antibiotics may increase susceptibility to STIs, 4 papers, 1 webinar, 2 jobs, more.

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## **California Stories**

### **California's New Sex Education Requirements**

Emily Bazar, California Healthline | 3.2

California schools are revamping their lesson plans to comply with a new state law that requires them to teach a sex education program at least once in middle school and once in high school.

Previously, districts were required to teach HIV prevention, but sex education was not required.

“Over 90 percent of schools were teaching some sex education, but because it wasn’t mandated, certain elements were slipping through the cracks,” said Phyllida Burlingame, reproductive justice policy director for the ACLU of Northern California.

“This bill creates a consistent, unified way that sex education and HIV education is taught in the classroom.”

The law, which took effect in January, requires the curriculum to include discussions of sexual orientation, gender identity and sex trafficking, as well as information about contraception and HIV treatment.

“This law has kind of caught up with the times that we live in,” said Keith Bray, general counsel for the California School Boards Association. “It’s 2016. The law reflects some awareness as to lifestyles and additional tolerance where it’s needed.”

The bill, authored by Assemblywoman Shirley Weber (D-San Diego), bolstered previous curriculum requirements and added new ones. Instruction must:

- Be age appropriate and medically accurate, and may not promote religious doctrine.
  - Recognize different sexual orientations and include same-sex relationships when providing examples of couples.
  - Include information about all FDA-approved methods of contraception and prevention of sexually transmitted infections (STIs).
  - Address gender identity, sexual assault, relationship abuse and sex trafficking.
  - Describe abstinence as the only certain way to prevent pregnancy, HIV and other STIs.
- However, abstinence-only instruction is not permitted.

Parents or guardians must be notified that their child will receive this instruction and be allowed to see the course materials in advance. The law allows them to opt out with a written request.

Because the bill was just signed into law last fall, districts are scrambling to comply.

“This will be a process, probably over the next six to eight months, when districts will catch up with the Legislature,” Bray said.

Some school officials have reached out to the San Francisco Unified School District, which a few years ago created a high school sex education curriculum called “Be Real. Be Ready.”

With some minor exceptions, that curriculum already meets the law’s requirements, said Christopher Pepper, the district’s health project coordinator.

“We make the curriculum available for other educators to use for free,” he said. “I know some teachers in Marin County are now using it.”

The San Francisco district is working to bring its middle school offerings into compliance, he said. The high school curriculum is taught as a separate, one-semester course, while middle schoolers get sex ed from science or physical education teachers.

“Sometimes, there’s just not time to fit in enough of those lessons,” Pepper said. “We’re working with middle schools to expand the number of lessons.”

Before the law, the Fresno Unified School District’s high school sex ed curriculum included six lessons taught in biology class, said Elisa Messing, director of curriculum, instruction and professional learning. This year, it has hired the group Fresno Barrios Unidos to teach four additional lessons to bring the curriculum into compliance.

At the middle school level, the district is training teachers to incorporate the new topics into the lessons they already teach, and it may consider contracting out to supplement middle school instruction in the future, Messing said.

“This is Beta year, we’re learning,” she said.

Barrios Unidos will start teaching lessons this week, the first of 183 presentations it expects to make by the end of the school year at 14 high schools, said executive director Socorro Santillan.

“Some parents and teachers think we’re giving the students this information because we want them to be sexually active,” she said. “But we’re giving them information they’re going to need to be able to thrive in their communities. For some students, the fastest way to end a college education is through an unintended pregnancy.”

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

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## **Condoms: How young is too young?: More Bay Area middle schools making them available to students**

Joyce Tsai, Contra Costa Times | 2.29

Available in a vast array of eye-catching colors and even candylike flavors, condoms are increasingly being distributed to teenagers to drive home a message about safe sex. But the question for many on both sides of the condom conundrum is: How young is too young?

The San Francisco Unified School District made waves earlier this week for its decision to approve the distribution of condoms to middle schoolers -- not en masse but to individuals who meet certain criteria. The move riled some parents and abstinence-preaching advocacy groups who maintain that school isn't the place for sixth-graders to be furnished with the means to practice safe sex -- or any kind of sex.

But San Francisco isn't alone. Oakland Unified School District adopted a similar policy in June 2014, and although the vast majority of school districts don't offer condoms to middle schoolers, some 25 school-based health centers in Contra Costa County do, without requiring parental consent.

"There wasn't pushback, and it wasn't controversial at all when the policy was passed ... because most parents want their kids to have the resources they need," said Mara Larsen-Fleming, the director of

health and wellness for the Oakland district. Larsen-Fleming pointed out that about 8.5 percent of Oakland Unified seventh-graders surveyed as part of the California Healthy Kids Survey in the 2014-15 school year reported being sexually active.

Although there are no national or statewide statistics on the issue, San Francisco Unified participated in a 2013 survey that found about 5.4 percent of its middle schoolers have had sex, according to the Centers for Disease Control and Prevention.

At the same time, there has been a historic decline in teen pregnancy during the past two decades. Since peaking in the early 1990s, teen pregnancy rates have declined 51 percent and teen births are down 61 percent, said Bill Albert of The National Campaign to Prevent Teen and Unplanned Pregnancy.

"There has been significant progress in all 50 states and among all racial and ethnic groups that is driven by the magic formula of less sex and more contraception," he said. "More teens are delaying sex, and those that are having sex are using contraception more consistently and carefully."

Still, nearly 2 in every 10 girls in this country will get pregnant by age 20, many from high-poverty areas, he said. And if you consider that just 22 states and Washington, D.C., require that public schools teach sex education, let alone provide young people with access to contraception, "it seems safe to say that the effort S.F. has undertaken is one that few other school districts have," Albert said.

But some parents said the whole idea of making condoms available to someone as young as 12 fills them with unease.

"Whoa, in middle school? I can't even imagine," said Shannon Urrutia, a Martinez resident who has a son in middle school in Pleasant Hill. "Sure, you hear about condoms in high school, but in middle school? On one hand, you know it's happening out there, and it's better that kids are safe, but it just seems too young -- and it goes against our religious beliefs."

At 25 school-based health centers -- four in middle schools -- that serve the West Contra Costa, Mt. Diablo, Pittsburg, Antioch and John Swett school districts, all run by Contra Costa County Health Services, students 12 years and older can access primary health care and reproductive health services, which can include being given condoms, said Contra Costa County Health Services spokeswoman Victoria Balladares. That's in accordance with California laws that require health clinics to offer the services -- no parental consent or notification required.

Likewise, San Jose Unified doesn't provide condoms to its students; however, two school-based health centers at the north end of the district in downtown San Jose, which are run by the Santa Clara County Public Health Department, will offer condoms to students ages 12 and older, consistent with California law.

"It's consistent with the practices of other school-based health centers in other counties," said Jason Willis, the district's assistant superintendent of community engagement and accountability.

Oakland's decision came about when staff from the district's school-based health center partners expressed concern that although they were allowed by school policy to provide condoms to high school students, they were prohibited from giving them out to middle schoolers even though they were seeing a number that were at risk, Larsen-Fleming said.

"The numbers of students were few and far between, but the ones that need them are at really high risk for sexual exploitation, STDs and pregnancy, and there are a lot of compounding risks," she said. "(The clinicians) really felt their hands were tied in helping these students, so they asked us to relook at the policy."

Similar to the policy adopted in San Francisco, at Oakland's school-based health centers, "no one who just comes in and asks for condoms just gets condoms and walks out," said Joanna Bauer, who supervises a clinic in East Oakland. Instead, middle schoolers also get referrals to resources, counseling and health education. They must undergo a pre-screening and psychosocial assessment by a school nurse or another licensed health professional, said district spokesman Isaac Kos-Read. San Francisco and Oakland do not allow parents to opt out of their programs, nor do the programs require parental consent.

Albert said the research is absolutely clear that providing condoms to young people doesn't encourage them to have more sex or at younger ages. But Camille Giglio, director of California's Right to Life committee and spokeswoman for the No to Irresponsible Sex Education Coalition, said that she was troubled by the new policy.

"It's sending the wrong message to students," she said. "It is saying that your body is a playground for someone else, ... and a lot of kids don't have enough discipline to continue using them or other types of contraception."

Lupe Rodriguez, a spokeswoman from Planned Parenthood in Mar Monte, said the move to offer condoms to middle school students at school-based health centers, where nurses, counselors and trained professionals can help students make more responsible decisions, is more important than ever.

"Young people are being exposed to more sexually charged content through social media and YouTube these days at a younger age," she said.

Nicole Peters, who has a fifth-grader at Hidden Valley Elementary in Martinez, recalled it was in middle school that many of her own friends started to become sexually active, so why be in denial about it?

"I'm one of those parents that believes in being open with my kids," she said. "It comes down to parents to teach their kids values and morals -- and to do all we can to prepare them to make the right decisions."

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

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## National Stories

### **HIV in Rhode Island: Newly diagnosed men often 'hooked up' online**

As reported by Medical News Today | 2.29

More than 60 percent of Rhode Island men who have sex with men (MSM) diagnosed with HIV in 2013 reported meeting sexual partners online in the preceding year, according to a study published in the journal *Public Health Reports*.

Study authors at Brown University, The Miriam Hospital, and the Rhode Island Department of Health said companies that produce hookup websites and apps should partner with public health groups, to share public health messages about the risks of sexual encounters arranged online. For instance, sites and apps could provide affordable advertising access to help prevent infection in communities that are most impacted by HIV.

In 2013, 74 Ocean State residents were newly diagnosed with HIV. Three in five were gay, bisexual, or other MSM, and of those 43 people, 22 told researchers they believe a man they met online gave them the virus, according to the study published online in the journal *Public Health Reports*. The research team interviewed 70 of the state's 74 newly diagnosed people for the study.

"This is a statewide study that included nearly all individuals newly diagnosed with HIV across an entire state," said Amy Nunn, associate professor of Public Health and Medicine at Brown University and director of the Rhode Island Public Health Institute. "This is one of the first studies to document how common Internet site use is among people newly diagnosed with HIV and highlights important opportunities to partner with hookup sites to advance public health."

Five sites and apps, some of which are also used by women, were the most popular: Grindr, Manhunt, Scruff, Adam4Adam and Craigslist. Study lead author Dr. Philip Chan, assistant professor of medicine in the Alpert Medical School and director of at the STD Clinic at The Miriam Hospital, said the widely used sites are part of the lifestyle and culture among many gay and bisexual men and can lead to lasting relationships, not just health risks. The goal of the research, therefore, is not to stigmatize sex or men who use the sites, he and Nunn said, but to instead to inspire partnerships with companies to include more information that could slow the spread of HIV.

"Prevention messaging is a vital tool in our work to prevent new HIV transmissions in Rhode Island," said study co-author Dr. Nicole Alexander-Scott, director of the Rhode Island Department of Health. "A study like this is an urgent call to action for greater collaboration around education to address the health needs of men who have sex with men. The rate of new HIV diagnoses among men who have sex with men represents an unacceptable health disparity that absolutely must be addressed."

### **Seeking public health partnership**

"Across the U.S. we are seeing MSM as the number one risk group for HIV infection," Chan added. "On these online hookup sites, many young MSM are meeting sex partners. It's really an under recognized and under utilized approach we should be using to reach out to and engage this group."

To date, public health officials have struggled to sustain informational campaigns on sites and apps that charge for advertising, either because they have no discounts for non-profits or don't discount enough, Chan said. Craigslist and Scruff ads are free, the authors said, but staff at small non-profit or government agencies face logistical challenges in messaging in these venues, such as having to continually repost ads.

"One of the challenges this study highlights is that it's prohibitively expensive for many organizations who focus on public health promotion to buy ads on these apps and websites," Nunn said. "Reducing disease transmission should be part of these organizations' corporate social responsibility programs."

The researchers document recent advertising costs in their study, which can quickly run into the thousands of dollars.

"We would like to see more of these companies stepping up to the plate to work with public health departments," Chan said.

The urgency has not abated since 2013, Chan said. In 2014, the study notes, HIV infections in Rhode Island grew by 97 new diagnoses, again mostly among MSM.

Many of the individuals newly diagnosed in Rhode Island were diagnosed late in the course of their infection, the study showed. Nunn said this suggests that they may have been living HIV for a long time, and potentially unknowingly transmitting HIV to other people, including partners they met online. These findings highlight opportunities to disrupt HIV transmission, she said, by partnering with websites to deliver prevention messaging services that promote routine HIV testing, treatment, and uptake of pre-exposure prophylaxis (PrEP), a once a day pill that can dramatically reduce HIV acquisition risks for HIV negative individuals.

Chan and Nunn gave sites such as Adam4Adam and Manhunt credit for recently beginning to provide a way for users to list their HIV status when they fill out a profile. Users, for example, can opt to declare they are positive or negative and, if so, whether they are taking PrEP. Similarly, Scruff allows users to document whether they are currently taking PrEP.

[Public Health Reports / March–April 2016 / Volume 131: Online Hookup Sites for Meeting Sexual Partners Among Men Who Have Sex with Men in Rhode Island, 2013: A Call for Public Health Action .](#)

Philip A. Chan, MD, MS Caitlin Towey, MPH Joanna Poceta, BA Jennifer Rose, PhD Thomas Bertrand, MPH Rami Kantor, MD Julia Harvey, BA E. Karina Santamaria, MPH Nicole Alexander-Scott, MD MPH Amy Nunn, ScD, MS. *Public Health Reports*. Published online February 26, 2016.

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

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## **HIV Infection Despite PrEP: 6 Things You Need to Know**

Damon Jacobs, JD Davids, Myles Helfand, TheBodyPRO | 2.26

A thorough case study has revealed the likely acquisition of HIV by a 43-year-old gay man in Toronto who was adherent to pre-exposure prophylaxis (PrEP). Presented at CROI 2016 on Feb. 25, this is the first documented case of "PrEP failure," and it is spurring a lot of community and scientific discussion.

"PrEP works when taken. Very rarely, PrEP with FTC/TDF [emtricitabine/tenofovir, Truvada] may fail to provide full protection against rare multidrug resistant viruses," said noted PrEP and HIV prevention researcher Robert Grant in an interview with BETA. "If that happens, HIV treatment is highly effective and prolongs life to normal levels and makes people less infectious."

It's not surprising that HIV community members, educators and care providers have many questions and concerns when they learn about this particular case. Let's break down the information to address some of the top questions we're likely to hear from people who are on PrEP, considering PrEP use or living with HIV.

### **Why didn't PrEP prevent HIV infection in this person?**

PrEP did not prevent infection in this instance because the person was exposed to a strain of HIV that had become resistant to several antiretroviral medications. These medications included (but were not limited to) tenofovir and emtricitabine, the two antiretrovirals in Truvada, which is currently the only PrEP regimen approved in the U.S.

It is estimated that well below 1% of people living with HIV are resistant to these two medications; even fewer also have a detectable viral load. Even if a person had this rare strain, if their viral load were undetectable, it would be extremely unlikely -- borderline impossible, research has found -- that he or she could transmit the virus to anyone.

Nonetheless, based on this new case, it is now known that consistent adherence to PrEP might not be enough to protect people from exposure to this particular HIV strain.

### **Does this mean that PrEP is not as effective as previously thought?**

No, PrEP is still as effective as we thought it was. It's very effective.

Knowledgeable HIV doctors and educators generally use a "99% effective" estimate when explaining how well PrEP works. Experts knew that as PrEP implementation expanded, it was possible we would see "outliers." So the 99% figure still applies.

Again, it is believed that less than 1% of individuals living with HIV carry this rare strain, and only a subset of those are likely to have a detectable viral load. If it were easy to transmit these particular drug-resistant mutations, there would likely be a lot more people testing HIV positive with them, but that has not happened.

There are approximately 40,000 individuals using PrEP in the U.S., and this type of transmission has never been seen before.

### **Now that this person has HIV, will HIV treatment work for him?**

According to the study, yes. The person was prescribed HIV treatment quickly and achieved an undetectable viral load less than a month after being diagnosed with HIV.

Initially, the man's level of HIV drug resistance was unknown, so when he was first diagnosed, doctors maintained his tenofovir/emtricitabine prescription and added two additional active antiretrovirals -- raltegravir (Isentress) and ritonavir (Norvir)-boosted darunavir (Prezista) -- to form a complete treatment regimen. After testing revealed that his strain of HIV had developed at least some level of resistance to several HIV drugs across multiple classes (including integrase inhibitors), he was switched to a more unusual regimen: dolutegravir (Tivicay), darunavir/cobicistat (Prezcobix) and rilpivirine (Edurant).

In the 12 weeks since beginning his new regimen, the man's HIV viral load has remained undetectable.

**Are there ways for people with HIV to find out if PrEP would not work for their partners, due to the possibility that they may have this type of resistant virus?**

When people are newly diagnosed with HIV, care providers are expected to perform a genotypic resistance test in order to make sure they do not prescribe antiretrovirals that the person is already resistant to. That test would reveal if the person has resistance to tenofovir/emtricitabine.

But keep in mind, this strain is rare. If people with HIV have this strain, it is most likely that their clinician would have informed them already. Even if they do have this strain, they can eliminate nearly all risk of HIV transmission to any negative partner, with or without PrEP, by adhering to their HIV medications and maintaining an undetectable viral load.

In the Toronto case, it is believed that the person from whom the PrEP user acquired HIV had not complied with treatment, and that is how his strain became resistant. That can't be confirmed at this time, however, because when the case was presented it was unknown exactly whom the PrEP user acquired HIV from. But we know it's extremely unlikely for people who are adherent to their HIV medications to become resistant to them.

**Will there be other kinds of PrEP that could block this type of resistant virus?**

There are many kinds of PrEP currently being studied -- for instance, PrEP using different medications (such as maraviroc [Selzentry, Celsentri]), as well as different modes of administration such as gels and injectables. It's difficult to say at this time whether these new forms will offer adequate protection from this rare strain, or from other strains that are resistant to the drugs or drug classes used for those particular forms of PrEP.

**Where can I see the actual research related to this case?**

You can watch the case study presentation at CROI 2016 [via archived webcast](#).

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

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## **Antibiotics may increase susceptibility to sexually transmitted infections**

Christopher Packham, Medical Xpress | 2.3

Commensal microbiota, populations of bacteria that inhabit the tissues of larger organisms, often have complex relationships with their hosts. Researchers have been aware for some time that commensal microbiota play a role in antiviral immunity by producing immune inductive signals that trigger inflammasome responses, among other things.

However, the role of dysbiosis on antiviral immunity hasn't been studied. Dysbiosis describes the loss of bacterial diversity within a microbiome, and the direct role that commensal microbiota play in antiviral immunity suggests that such loss would facilitate viral infections. Recently, a collaborative of Korean and Japanese scientists conducted a study into the effects of antibiotic-induced dysbiosis on antiviral immunity, and have published their results in the Proceedings of the National Academy of Sciences.

The researchers investigated the mechanisms of commensal microbial immunity on the genital mucosa by treating mice with antibiotics for four weeks and then exposing them to HSV-2. A control group received placebo. They report that the antibiotics caused dysbiosis within the vaginal microbiota, and resulted in a dramatic increase in innate immune response—specifically, they noted increases in an alarmin called IL-33, which blocked effector T cells from migrating into the vaginal tissues and secreting antiviral cytokines.

Antibiotic-treated mice succumbed to HSV-2 infection dramatically faster than control mice. They exhibited more severe pathology and all mice treated with antibiotics prior to viral exposure died within 11 days of infection. "Taking these data together, we find that depletion of commensal bacteria results in a severe defect in antiviral protection following mucosal HSV-2 infection," the researchers write.

By analyzing stool and vaginal washes from both groups of mice, they determined that antibiotic treatment induced an imbalance in the microbial composition of the vaginal mucosa. Further, they were able to determine that no single species of bacteria was responsible for the antiviral immunity effects of the commensal microbiome; rather, it was the imbalance of the microbiotic population that accounted for the effects.

Proteomic analysis revealed changes in the abundance of certain vaginal wash proteins; the researchers hypothesize that factors driven by inflammatory damage of epithelial cells during antibiotic treatment modulate local immunity. Further, an innate immune cytokine, IL-33, is a big contributor to the impairment of antiviral immunity to mucosal HSV-2 infection. They corroborated the role of IL-33 in a supporting experiment in which they injected mice with recombinant IL-33 for eight days before viral infection. These mice died much faster than control mice.

The authors write, "Our present study demonstrates that inhibitory signals induced by the depletion of commensal microbiota also affect antiviral immunity. Taken together, our findings provide a unique insight into the role of commensal bacteria in maintaining the integrity of surface barrier epithelial cells by preventing pathogenic bacteria colonization, thereby supporting a micro-environment conducive to antiviral defense."

They note that their results are clinically relevant, with implications regarding the use of oral antibiotics and increased susceptibility to sexually transmitted infections, as well as other infectious viruses.

**Reference:**

Dysbiosis-induced IL-33 contributes to impaired antiviral immunity in the genital mucosa, *PNAS* 2016 ; published ahead of print January 25, 2016, [DOI: 10.1073/pnas.1518589113](https://doi.org/10.1073/pnas.1518589113)

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

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## **FDA takes additional action to better understand safety of Essure, inform patients of potential risks**

Press Release, FDA | 2.29

The U.S. Food and Drug Administration announced today actions to provide important information about the risks of using Essure and to help women and their doctors be better informed of the potential

complications associated with implantable forms of sterilization. The FDA issued a new, mandatory clinical study for Essure to determine heightened risks for particular women. The FDA also intends to require changes to product labeling, including a boxed warning and a Patient Decision Checklist to help to ensure women receive and understand information regarding the benefits and risks of this type of device. The FDA has issued a draft guidance to provide the public an opportunity to comment on the proposed language to be included in these warnings. Since Essure's approval in 2002, the agency has continued to monitor Essure's safety and effectiveness by reviewing the medical literature, clinical trial information, post-approval study data and medical device reports submitted to the agency. The new actions announced today take additional steps and follow the agency's careful evaluation of available information.

"The actions we are taking today will encourage important conversations between women and their doctors to help patients make more informed decisions about whether or not Essure is right for them," said William Maisel, M.D., M.P.H., deputy director for science and chief scientist at the FDA's Center for Devices and Radiological Health. "They also reflect our recognition that more rigorous research is needed to better understand if certain women are at heightened risk of complications."

Essure is a permanent form of birth control that involves the insertion of flexible coils through the cervix and vagina into the fallopian tubes. Over a period of about three months, scar tissue forms around the inserts and creates a barrier that keeps sperm from reaching the eggs, thus preventing conception. While the scar tissue forms, women must use an alternative form of birth control. Over the past 14 years, FDA has reviewed a significant amount of information related to the use of Essure. While the FDA believes Essure remains an appropriate option for the majority of women seeking a permanent form of birth control, some women may be at risk for serious complications. These may include persistent pain, perforation of the uterus or fallopian tubes from device migration, abnormal bleeding and allergy or hypersensitivity reactions.

The draft guidance issued today by the FDA regarding permanent hysteroscopically-placed sterilization devices aims to increase patient and physician understanding of the potential risks associated with this type of device. The draft guidance provides the public an opportunity to comment on the language that once finalized, will be included in the product labeling to communicate to health care practitioners and patients the potential serious complications that can occur in some women. The Agency intends to require a mandatory box warning on the product explaining the adverse events that have been associated with these devices, including their insertion and/or removal procedures.

The draft guidance also includes proposed language for the "patient decision checklist," for doctors to discuss with patients to better communicate risks and help to ensure an informed decision-making process. The checklist will also help doctors discuss the importance of undergoing a "confirmation" test three months after the device is implanted to determine whether the implants are properly placed and that scar tissue has formed to prevent pregnancy. The checklist should be completed and signed by the patient and physician prior to proceeding with a permanent hysteroscopic sterilization procedure, such as Essure.

The FDA has also ordered Bayer, the company that manufactures Essure, to conduct a new postmarket surveillance study designed to provide important information about the risks of the device in a real-world environment. Bayer will be required to develop and conduct a post-market study that will provide data to help the agency to better understand the risks associated with Essure and compare them to laparoscopic tubal ligation. This includes the rates of complications including unplanned pregnancy,

pelvic pain and other symptoms, and surgery to remove the Essure device. The study will also evaluate how much these complications affect a patient's quality of life. Additionally, it will collect information to identify reasons for why some patients don't have a confirmation test to ensure that Essure has been properly placed three months after insertion. The FDA will use the results of this study to determine what, if any, further actions related to Essure are needed to protect public health.

The FDA is seeking comment from the public, industry, and other stakeholders on this draft guidance. The docket will be open for 60 days.

The FDA, an agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

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

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## 'Female Viagra' safety, efficacy questioned in new study

Yvette Brazier, Medical News Today | 2.29

The drug flibanserin, approved last year by the US Food and Drug Administration to boost sexual desire in women who are entering the menopause, has limited benefits and produces negative effects, say findings published in JAMA Internal Medicine.

Hypoactive sexual desire disorder (HSDD), also known as female sexual interest/arousal disorder, affects 10-40% of women.

HSDD is defined as "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity," accompanied by "marked distress and interpersonal difficulty" that does not stem from a non-sexual mental disorder, medication, relationship stress or another medical condition.

Flibanserin - dubbed the "female Viagra" - was approved last year by the Food and Drug Administration (FDA) in a high-profile decision that attracted attention from the public and health professionals alike.

Added to safety issues were concerns about the medicalization of women's sexuality. It was unclear whether the benefits were worth the risks, and questions were raised about the influence of the pharmaceutical lobby on FDA decisions.

Sprout Pharmaceuticals purchased the rights to flibanserin after the FDA originally rejected it. They aroused support, including helping to create and fund the "Even the Score" advocacy campaign. The campaign claimed that sexism had motivated the rejection, rather than scientific evidence.

Within 48 hours of FDA approval, Valeant Pharmaceuticals, of which Sprout was a division, purchased the rights to flibanserin for about \$1 billion in cash.

Dr. Loes Jaspers, of the Erasmus University Medical Center in Rotterdam, the Netherlands, and coauthors carried out a meta-analysis of the records of clinical trials for 5,914 women.

### **Desired effects are limited, but side-effects are significant**

The trials, five of which were published and three unpublished, investigated the efficacy and safety of the medication for treatment of HSDD.

The findings indicate that flibanserin results, on average, in a monthly increase in satisfaction of one half of one sexual event, but that it significantly increases dizziness, sleepiness, nausea and fatigue among women using it. The overall impression of the women surveyed was that the drug led to either minimal or no improvement.

The studies reviewed were randomized clinical trials, but the quality of evidence was considered as "very low," due to design limitations and the indirectness of evidence.

Moreover, the authors point out that the efficacy outcomes in the published results were more favorable than those in the unpublished studies.

They conclude that the benefits of flibanserin are marginal, especially when taking into account the adverse effects.

The team calls for future studies to include women from diverse populations, and especially those who already have other conditions or considerations, including surgical menopause, and women who are using other medications.

In a linked commentary, Dr. Steven Woloshin and Dr. Lisa M. Schwartz, of the Dartmouth Institute for Health Policy and Clinical Practice in Lebanon, NH, say:

"The flibanserin saga is unsatisfying. The FDA approved a marginally effective drug for a non-life-threatening condition in the face of substantial, and unnecessary, uncertainty about its dangers. Women with distressing sexual desire problems need good treatments. We all need a drug approval process that delivers good decisions based on adequate evidence."

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

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## **Scientific Papers/Conference Abstracts**

### **Evaluation of Routine HIV Opt-Out Screening and Continuum of Care Services Following Entry into Eight Prison Reception Centers — California, 2012**

Lucas KD, Exkert V, Behrends CN, et al. *MMWR* 2016;65(7):178-181

Early diagnosis of human immunodeficiency virus (HIV) infection and initiation of antiretroviral treatment (ART) improves health outcomes and prevents HIV transmission (1,2). Before 2010, HIV testing was available to inmates in the California state prison system upon request. In 2010, the California Correctional Health Care Services (CCHCS) integrated HIV opt-out screening into the health assessment for inmates entering California state prisons. Under this system, a medical care provider

informs the inmate that an HIV test is routinely done, along with screening for sexually transmitted, communicable, and vaccine-preventable diseases, unless the inmate specifically declines the test. During 2012–2013, CCHCS, the California Department of Public Health, and CDC evaluated HIV screening, rates of new diagnoses, linkage to and retention in care, ART response, and post-release linkage to care among California prison inmates. All prison inmates are processed through one of eight specialized reception center facilities, where they undergo a comprehensive evaluation of their medical needs, mental health, and custody requirements for placement in one of 35 state prisons. Among 17,436 inmates who entered a reception center during April–September 2012, 77% were screened for HIV infection; 135 (1%) tested positive, including 10 (0.1%) with newly diagnosed infections. Among the 135 HIV-positive patient-inmates, 134 (99%) were linked to care within 90 days of diagnosis, including 122 (91%) who initiated ART. Among 83 who initiated ART and remained incarcerated through July 2013, 81 (98%) continued ART; 71 (88%) achieved viral suppression (<200 HIV RNA copies/mL). Thirty-nine patient-inmates were released on ART; 12 of 14 who were linked to care within 30 days of release were virally suppressed at that time. Only one of nine persons with a viral load test conducted between 91 days and 1 year post-release had viral suppression. Although high rates of viral suppression were achieved in prison, continuity of care in the community remains a challenge. An infrastructure for post-release linkage to care is needed to help ensure sustained HIV disease control.

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## **Transmission of Zika Virus Through Sexual Contact with Travelers to Areas of Ongoing Transmission — Continental United States, 2016**

Hills SL, Russell K, Hennessey M, et al. *MMWR* Early Release 2016;65

Zika virus is a flavivirus closely related to dengue, West Nile, and yellow fever viruses. Although spread is primarily by *Aedes* species mosquitoes, two instances of sexual transmission of Zika virus have been reported (1,2), and replicative virus has been isolated from semen of one man with hematospermia (3). On February 5, 2016, CDC published recommendations for preventing sexual transmission of Zika virus (4). Updated prevention guidelines were published on February 23.\* During February 6–22, 2016, CDC received reports of 14 instances of suspected sexual transmission of Zika virus. Among these, two laboratory-confirmed cases and four probable cases of Zika virus disease have been identified among women whose only known risk factor was sexual contact with a symptomatic male partner with recent travel to an area with ongoing Zika virus transmission. Two instances have been excluded based on additional information, and six others are still under investigation. State, territorial, and local public health departments, clinicians, and the public should be aware of current recommendations for preventing sexual transmission of Zika virus, particularly to pregnant women (4). Men who reside in or have traveled to an area of ongoing Zika virus transmission and have a pregnant partner should abstain from sexual activity or consistently and correctly use condoms during sex with their pregnant partner for the duration of the pregnancy (4).

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## **An estimate of the proportion of symptomatic gonococcal, chlamydial and non-gonococcal non-chlamydial urethritis attributable to oral sex among men who have sex with men: a case-control study**

Barbee LA, Khosropour CM, Dombrowski JC, et al. *Sex Transm Infect* 2016;92:155-160

### **Background**

Sexually transmitted infections (STIs) of the pharynx are common among men who have sex with men (MSM); the degree to which these infections are transmitted through oral sex is unknown.

### **Methods**

We conducted a case-control study of MSM attending Public Health—Seattle & King County STD Clinic between 2001 and 2013 to estimate the proportion of symptomatic urethritis cases attributable to oral sex using two methods. First, we categorised men into the following mutually exclusive behavioural categories based on their self-reported sexual history in the previous 60 days: (1) only received oral sex (IOS); (2) 100% condom usage with insertive anal sex plus oral sex (PIAI); (3) inconsistent condom usage with anal sex (UIAI); and (4) no sex. We then determined the proportion of cases in which men reported the oropharynx as their only urethral exposure (IOS and PIAI). Second, we calculated the population attributable risk per cent (PAR%) associated with oral sex using Mantel–Haenszel OR estimates.

### **Results**

Based on our behavioural categorisation method, men reported the oropharynx as their only urethral exposure in the past 60 days in 27.5% of gonococcal urethritis, 31.4% of chlamydial urethritis and 35.9% non-gonococcal, non-chlamydial urethritis (NGNCU) cases. The PAR% for symptomatic gonococcal urethritis, chlamydial urethritis and NGNCU attributed to oropharyngeal exposure were 33.8%, 2.7% and 27.1%, respectively.

### **Conclusions**

The pharynx is an important source of gonococcal transmission, and may be important in the transmission of chlamydia and other, unidentified pathogens that cause urethritis. Efforts to increase pharyngeal gonorrhoea screening among MSM could diminish STI transmission.

**View the paper online:** [Abstract](#)

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## **Predictors of provider recommendation for HPV vaccine among young adult men and women: findings from a cross-sectional survey**

Gerend MA, Shephard MA, Lustria MLA, et al. *Sex Transm Infect* 2016;92L104-107

### **Background**

Although physician recommendation is one of the strongest predictors of human papillomavirus (HPV) vaccination, it is unclear for whom physicians are recommending the vaccine. To help guide intervention efforts, this study investigated predictors of participant-reported physician recommendation for HPV vaccine among young adults in the USA.

### **Methods**

Women and men (N=223) aged 18–26 years were recruited online through Craigslist, a popular classified advertisements website. Ads were posted in the 25 largest US cities from September 2013 to March

2014. Participants completed a survey that assessed demographic and sociopolitical characteristics, sexual history, HPV vaccination history, and whether they had ever received a recommendation for HPV vaccine from a physician or healthcare provider.

### Results

Fifty-three per cent reported receiving a recommendation for HPV vaccine and 45% had received  $\geq 1$  dose of HPV vaccine. Participants who received a recommendation were over 35 times more likely to receive  $\geq 1$  dose of HPV vaccine relative to participants without a recommendation. Bivariable and multivariable correlates of provider recommendation were identified. Results from the multivariable model indicated that younger (aged 18–21 years), female, White participants with health insurance (ie, employer-sponsored or some other type such as military-sponsored) were more likely to report receiving a recommendation for HPV vaccine.

### Conclusions

Results suggest that physician recommendation practices for HPV vaccination vary by characteristics of the patient. Findings underscore the key role of the healthcare provider in promoting HPV vaccination and have important implications for future HPV vaccine interventions with young adults.

View the paper online: [Abstract](#)

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## Resources, Webinars, & Announcements

### 2016 STD Prevention Conference Now Accepting Abstracts

Abstracts are being accepted for the 2016 STD Prevention Conference. The Conference theme of *Transcending Barriers. Creating Opportunities.*, offers you the perfect opportunity to share your work in the areas of STD prevention research, program, policy, diagnosis, and treatment.

Abstract submissions are peer-reviewed for scientific content, logical presentation, timeliness, and current interest of the topic to the scientific community. Abstracts must be submitted no later than **Monday, April 25, 2016 at 11:59pm PST**. Instructions for submitting an abstract and a new resource to help guide you through the development process are available at the [2016 STD Prevention Conference website](#). The conference will be held September 20 - 23 in Atlanta.

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### Get Involved in National Women and Girls HIV/AIDS Awareness Day 2016

Office on Women's Health

[National Women and Girls HIV/AIDS Awareness Day](#) is an annual observance that raises awareness of the impact of HIV and AIDS on women and girls. Every year on March 10, local, state, and national organizations come together to educate and support women and girls in HIV prevention, treatment, and care. **The theme for this year is "The Best Defense Is a Good Offense."** When it comes to sex, the best defenses against HIV are getting tested, using condoms consistently, not abusing drugs or alcohol, and talking to your doctor about pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) if you think you're at risk for HIV.

Regardless of the type of relationship you are in, HIV prevention is key. Put your **#BestDefense** into play!

#### What can you do on March 10?

- Visit the [National Women and Girls HIV/AIDS Awareness Day website](#) for fact sheets, posters, and social media tools.
- Live near Washington, DC? Grab your girlfriends and [walk with us!](#)
- Plan a testing or educational event. Use these [event ideas](#).
- Talk to your girlfriends about the [steps to staying safe and protected from HIV](#).
- Join the National Women and Girls HIV/AIDS Awareness Day [Thunderclap](#).
- Use **#NWGHAAD** and **#BestDefense** to talk about how you are protecting yourself and others from HIV.

Meet the [2016 Ambassadors](#).

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## WEBINAR: STDs, the Genital Microbiome and HIV Transmission: What is Happening Down There?

**DATE:** March 10

**TIME:** 1:00 – 2:00 PM ET

Antiretroviral therapy (ART) dramatically reduces HIV transmission when used as treatment or as PrEP, but the global rate of new HIV infections currently outstrips our ability to provide ART. Most of these new HIV infections are acquired through sex, when the mucosal lining of the vagina, penis or rectum is exposed to HIV-infected genital fluids. Sexual HIV transmission is surprisingly inefficient, with a per-contact risk under 1% for most exposures. Today's presentation will focus on how this risk is dependent on the dynamic interaction between our immune system and microbes – both HIV, other STIs and the larger microbiome – at the mucosal surfaces of the genital tract and gut, and will highlight some challenges of translating these research findings into new HIV prevention strategies.

Dr. Rupert Kaul is dually trained as a clinical Infectious Disease specialist and a PhD immunologist, and is the director of the Infectious Diseases Division at the University of Toronto and University Health Network. His research is focused on the interaction between genital infections and mucosal immunology, and seeks to develop new ways to prevent and ameliorate HIV infection. This research is based in participant cohorts from Canada, Kenya, Uganda and South Africa, with the support of a University of Toronto / OHTN Endowed Chair in HIV Research.

On March 10 at 1:00 pm ET, participants can join the event by clicking [this link](#) and calling 800-619-7490.

**For more information:** [Click here](#)

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## Job/Internship Postings

### STI/HIV Social Worker – San Mateo County Public Health, STI Program

**Organization:** San Mateo County Public Health Division, Sexually Transmitted Infection Program

**Location:** San Mateo, CA  
**Salary:** \$4,985 - \$7,348 /Month  
**App. Deadline:** March 14

### **THE POSITION**

The San Mateo County Public Health Division's Sexually Transmitted Infection Program seeks a well-qualified STI/HIV Social Worker II/III to provide a variety of services including on-going clinic based case management and short term HIV/STI risk reduction counseling.

The current vacancy is located in San Mateo, CA, but will travel throughout the County to see clients at other sites, attend meetings, case conferences, etc.

Primary responsibilities will include:

Meet with clients at least twice a year to determine eligibility for program; intake process for all new clients; program enrollment; enrollment and registration into county, state and federal programs; psycho-social assessment; provide on-going support as needed; develop linkages for clients to adjunct services (MHA emergency housing and financial services; ACRC food vouchers; HRTC psychotherapy services; Medical-Psychiatry; Dental Services, Psychiatry; benefit services, and other resources as needed); one-to-one support (up to and including, medication adherence, wellness health promotion, appointment follow up, assist with travel to appointments, syringe exchange services, etc.); track clients; periodic check ins with patients who have fallen out of care; write reports or document work time spent with client in electronic medical records, statewide database, and other data keeping systems; meet with collaborators, and any other meetings with persons related to the program or on behalf of the client; attend monthly or bi-monthly provider case conferences; participate in specialized case conferences for patients; participate in all bi-monthly held mental health meetings; participate in monthly program team meetings; participate in monthly providers meeting; and participate in quarterly all staff meetings.

The ideal candidate will have experience with:

- Providing case management services to HIV clients;
- Professional, personal and/or volunteer experience in HIV care and prevention programs with varied populations;
- Risk/harm reduction counseling;
- Working as part of an integrated treatment team; and
- Knowledge of AIDS Drug Assistance Program (ADAP) and Office of AIDS Health Insurance Premium Payment (OA-HIPP).
- Fluency in both English and Spanish is strongly preferred

**For more information:** [Click here](#)

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## **STD/HIV Service Integration Unit Chief – CDPH STDCB**

**Organization:** California Department of Public Health, STD Control Branch  
**Location:** Richmond, CA

### **Job Summary**

Under the supervision of the Health Promotion and Healthcare Quality Improvement (HPHQI) Section Chief, the STD/HIV Service Integration Unit Chief establishes and maintains effective consultative and collaborative relationships with state, local, and non-governmental partners to enhance and integrate STD/HIV prevention and control activities. Within this role, the STD/HIV Service Integration Unit Chief leads a team of public health professionals in planning, implementing, evaluating, and improving projects and interventions related to HIV partner services, HIV prevention among STD patients, and quality STD clinical care among HIV-infected persons. This position oversees local health jurisdiction (LHJ) STD/HIV Service Integration funding including managing standardized processes for selection of awardees, approving budgets and activities within LHJ Scopes of Work, and providing ongoing monitoring of LHJ performance.

### **Required Qualifications**

- BA/BS degree with a major in a related field and four years of experience in administrative analysis or operations research; or an equivalent combination of education and experience
- Experience in public health program management
- Experience developing and maintaining collaborations with diverse partner groups
- Experience supervising staff
- Experience writing and/or managing grants, drafting formal progress reports, or similar
- Experience participating in a strategic planning and/or prioritization processes
- Experience with program evaluation, including planning, implementation, and monitoring, and the summarizing of results
- Proficiency with Microsoft applications: Word, Excel, PowerPoint, Outlook
- Basic content knowledge in STD epidemiology and prevention and control strategies, including knowledge of STD screening recommendations and other STD-related clinical interventions
- Knowledge of IRB and HIPAA guidelines associated with conducting public health evaluations and research
- Excellent and effective time management skills and ability to juggle multiple priorities and meet competing deadlines
- Leadership skills and independent initiative and drive
- Ability to know when to seek counsel on issues outside one's abilities or knowledge
- Excellent interpersonal and communication skills, including professionalism, diplomacy, and discretion in verbal and written communications, and ability to communicate professionally with multiple levels of staff

### **Preferred Qualifications**

- Master's degree in Public Health or related field and two or more years of public health work experience
- Experience working in the field of HIV Prevention, Care, or Surveillance
- Experience crafting and negotiating contracts and budgets
- Knowledge of basic medical terminology

### **\*\* Directions for applying to this position \*\***

Candidates interested in applying for this position, please visit the UCSF website at: <http://ucsfhr.ucsf.edu/careers/>. Click on 'Search openings' and enter in **44332** under 'Req number' to view the posting. Please submit your cover letter and resume electronically to the UCSF Careers website.

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Archives of previous STD Updates can be found [here](#). To unsubscribe or add colleagues' names, email [aaron.kavanaugh@cdphc.a.gov](mailto:aaron.kavanaugh@cdphc.a.gov). If you have an item related to STD/HIV prevention which you would like included, please send. No bibliographic questions please; all materials are compiled from outside sources and links are provided. No endorsement should be implied! Note: Some words may have been palced in [brackets] or replaced with blanks (\_\_\_\_) or asterisks (\*) in order to avoid filtering by email inboxes.

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