

THE AMERICAN ACADEMY OF HIV MEDICINE ■ FALL 2023

HIV SPECIALIST

Sexual Health

Syphilis in the United States

Forgotten but Important:
Trichomonas Vaginalis

Improving Sexual Health

Primary Care Providers and
Sexual History Assessment

Transgender and Gender-Diverse
Health Care

Sexual Health Education and
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By BRUCE J. PACKETT II

Executive Director, AAHIVM

AS THE LEAVES CHANGE COLOR and the air turns crisper, we welcome you to the Fall 2023 issue of the *HIV Specialist*. This season, we once again carefully delve into a theme of paramount importance to everyone involved in the health care space: sexual health. Our exploration is guided by the World Health Organization's comprehensive definition of sexual health, which encompasses physical, emotional, mental, and social well-being in relation to sexuality. It is a state far more profound than mere absence of disease, dysfunction, or infirmity. Sexual health demands a positive and respectful approach to sexuality and sexual relationships, ensuring pleasurable and safe experiences, free from coercion, discrimination, and violence.

We are also timing the theme of this issue with the September 2023 launch of Course One (of eight planned Courses) of the Academy's Comprehensive Sexual Health Curriculum for providers, with the first course focusing on communication matters with patients around sexual health. Please visit www.sexualhealthcurriculum.com for more information and to engage with Course One.

In this issue, we've assembled a collection of thought-provoking articles that illuminate various facets of sexual health and how it touches our lives, both personally

and within the health care realm. Our aim is to empower individuals and health care providers with knowledge and tools to foster a culture of sexual health that is inclusive, informed, and compassionate. Highlighted in this issue are the following:

1. Syphilis in the United States: A Practical Overview for Health Care Providers delves into the alarming rise of syphilis cases and underscores the urgent need for consistent testing and early treatment.

2. *Trichomonas Vaginalis* among Cisgender Women with HIV sheds light on trichomoniasis, a sexually transmitted infection more prevalent than some of the better-known STIs, emphasizing the importance of routine screening for cisgender women with HIV.

3. Addressing Barriers and Improving Sexual Health: Tools for Providers and Patients offers valuable insights gleaned from National Coalition for Sexual Health focus groups, illuminating the barriers to sexual health and how providers can ensure their patients receive the sexual health care they deserve.

4. How Primary Care Providers Can Approach Psycho-Sexual History Assessment in a Medical Clinic provides a practical roadmap for health care providers to integrate a comprehensive sexual history assessment into their patient interactions, drawing from the CDC's "five P" approach and an added "sixth P."

5. Transgender and Gender-Diverse Health Care and Sexual Health spotlights the unique needs of transgender and gender-diverse

individuals concerning sexual health—from establishing respect for their identities to providing gender-affirming care and addressing specific considerations for youth.

6. Sexual Health Education and Care for Youth with Disabilities underscores the critical need for comprehensive sexual health education, especially for youth with disabilities. The article outlines ways in which providers can address their unique needs, reducing the risk of STIs, unintended pregnancies, and victimization.

In our accredited Continuing Education (CE) article, "**It's More Than Just a Blue Pill: Sexual Health, Aging, and Quality of Life,**" Jeffrey Kwong, DNP, MPH, AGPCNP-BC, FAANP, FAAN, AAHIVS, enlightens us on the significance of sexual health in aging, strategies to address the sexual health needs of older adults, and incorporating prevention strategies for those aging with HIV and those at risk.

Our "At the Forefront" segment features an interview on a recent graduate of the HIV Clinical Leadership Fellowship Program, offering a glimpse into the passion and dedication of future HIV providers.

We hope that this issue inspires conversations, sparks understanding, and empowers you to champion sexual health. Thank you for joining us on this journey of enlightenment and empowerment. Together, let us strive for a world where sexual health is a fundamental right, free from stigma, discrimination, and violence, in addition to being a critical component of ending the HIV epidemic.

A stylized, handwritten signature in black ink, appearing to read "B. J. Packett".

IN THE NEWS

NIH Selects Dr. Jeanne Marrazzo as Director of the National Institute of Allergy and Infectious Diseases

LAURENCE A. TABAK, DDS, PhD, acting director for the National Institutes of Health, has named Jeanne M. Marrazzo, MD, as director of NIH's National Institute of Allergy and Infectious Diseases (NIAID). Dr. Marrazzo is currently the director of the Division of Infectious Diseases at the University of Alabama at Birmingham. She is expected to begin her role as NIAID Director in the fall. NIAID conducts and supports basic and applied research to better understand, treat, and ultimately prevent infectious, immunologic, and allergic diseases.

"Dr. Marrazzo brings a wealth of leadership experience from leading international clinical trials and translational research, managing a complex organizational budget that includes research funding and mentoring trainees in all stages of professional development," said Dr. Tabak. "I look forward to welcoming Dr. Marrazzo to the NIH leadership team. I also want to extend my gratitude to Hugh Auchincloss, Jr., MD, for serving as acting director of NIAID after long-time director Anthony S. Fauci, MD, stepped down in December 2022."

As NIAID director, Dr. Marrazzo will oversee NIAID's budget of \$6.3 billion, which supports research to advance the understanding, diagnosis, and treatment of infectious, immunologic, and allergic diseases. NIAID supports research at universities and research organizations around the United States and across NIAID's 21 laboratories, including the Vaccine Research Center on NIH's main campus in Bethesda, Maryland, and the Rocky



Jeanne M. Marrazzo, MD

Mountains Laboratories in Hamilton, Montana. NIAID also has a unique mandate to respond to emerging and re-emerging public health threats at home and abroad. The NIAID research response to outbreaks of infectious diseases, from HIV to Ebola to COVID-19, has led to new therapies, vaccines, diagnostic tests, and other technologies.

Dr. Marrazzo's research in discovery and implementation science has focused on the human microbiome, specifically as it relates to female reproductive tract infections and hormonal contraception; prevention of HIV infection using biomedical interventions, including PrEP and microbicides; and the

pathogenesis and management of bacterial vaginosis, sexually transmitted diseases in HIV-infected persons, and management of antibiotic resistance in gonorrhea. She has been a principal investigator on NIH grants continuously since 1997 and has served frequently as a peer reviewer and advisory committee member. Dr. Marrazzo also has served as a mentor to trainees at all stages of professional development, including on NIH-funded training grants, and was the recipient of the American Sexually Transmitted Diseases Association's Distinguished Career Award, the highest recognition of contributions to research and mentoring in the field.

Dr. Marrazzo is a Fellow of the American College of Physicians and of the Infectious Diseases Society of America and is board certified in infectious disease. She earned her bachelor's in biology from Harvard University, Cambridge, Massachusetts; her MD from Thomas Jefferson University, Philadelphia; and a Master of Public Health in Epidemiology from the University of Washington, Seattle. Dr. Marrazzo also has chaired the American Board of Internal Medicine (ABIM) Council, and the ABIM Infectious Disease Specialty Board.

NIAID conducts and supports research—at NIH, throughout the United States, and worldwide—to study the causes of infectious and immune-mediated diseases, and to develop better means of preventing, diagnosing, and treating these illnesses. News releases, fact sheets, and other NIAID-related materials are available on the NIAID website.

About the National Institutes of Health (NIH)

NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services.

NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

IN THE NEWS

‘Conscience’ Bills Let Medical Providers Opt Out of Providing a Wide Range of Care

BY CARLY GRAF

A NEW MONTANA LAW will provide sweeping legal protections to health care practitioners who refuse to prescribe marijuana or participate in procedures and treatments such as abortion, medically assisted death, gender-affirming care, or others that run afoul of their ethical, moral, or religious beliefs or principles.

The law, which goes into effect in October, will gut patients’ ability to take legal action if they believe they didn’t receive proper care due to a conscientious objection by a provider or an institution, such as a hospital.

So-called medical conscience objection laws have existed at the state and federal levels for years, with most protecting providers who refuse to perform an abortion or sterilization procedure. But the new Montana law, and others like it that have passed or been introduced in statehouses across the U.S., goes further, to the point of undermining patient care and threatening the right of people to receive lifesaving and essential care, according to critics.

“I tend to call them ‘medical refusal bills,’” said Liz Reiner Platt, the director of Columbia Law School’s Law, Rights, and Religion Project. “Patients are being denied the standard of care, being denied adequate medical care, because objections to certain routine medical practices are being prioritized over patient health.”

This year, 21 bills instituting or expanding conscience clauses have been introduced in statehouses, and two have become law, according to the nonprofit Guttmacher Institute. Florida lawmakers passed legislation that allows providers and insurers to refuse any health service that violates ethical beliefs. Montana’s law goes further, prohibiting the assignment of health workers to provide, facilitate, or refer patients for abortions unless the providers have consented in writing. South Carolina, Ohio, and Arkansas previously passed bills.

Supporters of the Montana law, called the Implement Medical Ethics and Diversity Act, say it fills gaps in federal law, empowering more medical professionals to practice medicine based on their conscience in circumstances beyond abortion and sterilization.

The bill applies to a wide range of practitioners, institutions, and insurers, encompassing just about any type of health care and anyone who could be providing it. The

exception is emergency rooms, where the federal Emergency Medical Treatment and Labor Act takes precedence.

“We have technology that is pushing the limits of what is maybe ethical, and that is different in everybody’s minds,” said Republican state Rep. Amy Regier, who sponsored the Montana bill. “Having extra protections for people to practice according to their conscience as we continue down that path of innovation is important.”

Claims the bill discriminates against patients frustrate Regier, who said it’s about protecting health care providers. “Because someone has a conscientious objection to a specific service, they should be able to practice that way,” she said.

In 1973, federal regulations known as the Church Amendments were implemented after the Supreme Court’s *Roe v. Wade* decision made abortion legal nationwide. Under the Church Amendments, any institution that receives funding from the federal Department of Health and Human Services may not require health care providers to perform abortion or sterilization procedures if doing so would violate their religious or moral principles. Additionally, providers who refuse to perform these services may not be discriminated against for their decision.

Since then, at least 45 states have enacted their own abortion conscience clauses, according to the Guttmacher Institute. Of those, only 17 mandate that patients be notified of the refusal or limit the clause’s use in the case of miscarriage or emergency.

A March 2020 article in the American Medical Association’s *Journal of Ethics* said, “Clinicians who object to providing care on the basis of ‘conscience’ have never been more robustly protected than today.” Legal remedies for patients who receive inadequate care as a result have shrunk significantly, the article said.

But the wave of medical conscience bills introduced in statehouses since that article was published go beyond abortion to include contraception, sterilization, gender-affirming care, and other services. Opponents such as the American Civil Liberties Union, Planned Parenthood, and the Human Rights Campaign have been vocal opponents of this trend, criticizing it as a backdoor way to restrict the rights of women, LGBTQ+ community members, and other individuals.



Still, lawmakers across the country insist the right of doctors, nurses, pharmacists, and other medical providers to practice medicine in alignment with their beliefs is being infringed.

Some health care practitioners would “just be done” practicing medicine if forced to perform certain procedures such as abortion, Regier said. “That, to me, is what limits patient care.”

Many of the most sweeping bills are backed by organizations that have made it their business to promote this “conscience” agenda nationwide, such as the Christian Medical Association, Catholic Medical Association, and National Association of Pro-Life Nurses. Other groups launched a joint effort in 2020 with the explicit purpose of advancing state legislation that makes it easier for health care providers to refuse to perform a wide range of procedures, including abortion and types of gender-affirming care.

The organizations that started the initiative are the Religious Freedom Institute in Washington D.C., an Arizona-based nonprofit called the Alliance Defending Freedom, and the Christ Medicus Foundation in Michigan. According to its website, the coalition bolsters efforts to pass more sweeping medical conscience legislation, using methods including print and digital media campaign strategy, grassroots organizing,

and advocacy. After successes in Arkansas, Ohio, and South Carolina in 2021 and 2022, it turned to Montana and Florida. Regier said there are a “number of different organizations” pushing this type of legislation, including the Alliance Defending Freedom.

Most of these conscience laws are part of an “arsenal” to further social conservatism, and they are often religiously motivated, said Lori Freedman, a researcher and associate professor at the Bixby Center for Global Reproductive Health at the University of California-San Francisco.

Although federal law is meant to ensure people receive lifesaving care in an emergency, Freedman said, there are cases in which patients don’t receive the care they should simply because they don’t clear the bar of what a facility considers emergent.

While experts warn of the potential patient health consequences of these medical conscience bills, academics say placing a provider’s choice over their patient’s rights is itself a threat.

“These bills do not protect religious liberty because they make it impossible for people to follow their own religious and moral values in making major decisions,” Reiner Platt said.

About one in six patients in the U.S. are treated in Catholic health care facilities, according to Freedman. Many of those venues strictly regulate or prohibit certain procedures, such as abortion, but do not necessarily disclose that to patients. As of 2016, more than 25 percent of hospital beds in Montana were in such facilities, according to the ACLU. Freedman determined through her research that about one-third of people whose primary hospital was Catholic didn’t know of its religious affiliation and therefore were unaware of those limitations on their care.

The problem can extend to secular medical institutions, too. According to the AMA Journal of Ethics article, there are no rules requiring a patient be informed a provider is practicing conscientious objection, which means the patient might “unknowingly receive substandard care” and “even be harmed by” the provider’s refusals.

“As much as we like to think about these providers and their opinions, so much is determined at a larger, structural level,” Freedman said. “Abortion has been stigmatized, marginalized, and constrained,” and plenty of hospitals and physician groups have made great efforts to “make a very safe service somehow illegal to provide within their context.”

Reprinted from: KFF, August 3, 2023, <https://kffhealthnews.org/news/article/medical-conscience-bills-montana-florida-abortion/> (Accessed August 14, 2023)

IN THE NEWS

HHS Distributes \$47.8 Million in Grant Funding for Programs Expanding Access to Medications for Opioid Use Disorder, Addressing Other Facets of Overdose and Substance Use

THE DEPARTMENT of Health and Human Services (HHS), through its Substance Abuse and Mental Health Services Administration (SAMHSA), is announcing awards in five grant programs devoted to combating multiple facets of substance misuse and the nation's overdose epidemic. The grant awards total up to \$47.8 million.

The grant awards facilitate ongoing efforts throughout the nation in prevention, treatment, recovery support and harm reduction—the pillars of the HHS Overdose Prevention Strategy. The Overdose Prevention Strategy helps advance the Biden-Harris Administration's National Drug Control Strategy, which delivers on the call to action in President Biden's Unity Agenda for a whole-of-government approach to beat the overdose epidemic.

"Improving access to evidence-based treatment is one of the pillars of the HHS Overdose Prevention Strategy," said Secretary Xavier Becerra. "Funding multifaceted efforts to prevent and treat addiction reflects our commitment to helping Americans attain and sustain recovery."

"Drug overdoses have taken a heartbreaking toll on our country, and addressing untreated addiction is a key component of President Biden's National Drug Control Strategy," said White House Office of National Drug Control Policy (ONDCP) Director Dr. Rahul Gupta. "These grant programs will help further advance the Biden-Harris Administration's efforts to support drug prevention, treatment, harm reduction, and recovery services."

"The awarding of grants aimed at preventing and treating substance misuse is central to SAMHSA's daily work with communities throughout our nation," said Dr.



Miriam E. Delphin-Rittmon, the HHS Assistant Secretary for Mental Health and Substance Use, and the leader of SAMHSA. "The timing this year coincides with the implementation of a law that expands the number of prescribers eligible to provide medication for opioid use disorder treatment. Recovery is real and attainable."

The Consolidated Appropriations Act, 2023 (CAA), signed by President Biden in December 2022, removed the requirement for practitioners to have a waiver to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). All practitioners who have a current Drug Enforcement Administration registration that includes Schedule III authority may now prescribe buprenorphine for OUD in their practice if permitted by applicable state law.

The five grant programs are:

- Medication-Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant Program, distributing 21 awards totaling up to \$18.4 million: This program helps expand or enhance access to Medications for Opioid Use Disorder (MOUD). It is expected that this program will help to 1) increase the number of individuals with OUD receiving MOUD; and 2) decrease illicit opioid use and prescription opioid misuse.

- Emergency Department Alternatives to Opioids Demonstration Program, distributing 15 awards and a total of up to \$7.4 million: This program develops and implements alternatives to opioids for pain management in hospitals and emergency department (ED) settings. Strategies should include innovative approaches to the management of pain including team-based approaches that could be initiated in ED settings where

many individuals with such conditions seek acute care. Those approaches then could be continued in other organizational settings such as primary care or specialty pain management settings.

- Sober Truth on Preventing Underage Drinking Act (STOP Act) program, distributing 50 awards and a total of up to \$3 million: This program prevents and reduces alcohol use among youth and young adults ages 12-20 in communities throughout the United States. The program aims to: (1) address norms regarding alcohol use by youth, (2) reduce opportunities for underage drinking, (3) create changes in underage drinking enforcement efforts, (4) address penalties for underage use, and/or (5) reduce negative consequences associated with underage drinking (e.g., motor vehicle crashes, sexual assaults).

In addition, awardees will build on strategic plans that were developed under a Drug Free Communities award utilizing the strategic prevention framework model, which aims to address underage drinking behaviors.

- **Adult Reentry Program**, distributing 34 awards totaling up to \$13.6 million: This program expands substance use disorder (SUD) treatment and related recovery and reentry services to sentenced adults in the criminal justice system who have SUDs and/or co-occurring substance use and mental disorders – adults who are returning to their families and community following a period of incarceration in state and local facilities including prisons, jails, or detention centers. Maintaining treatment and recovery during this transition period is crucial to help prevent overdose, particularly for people whose opioid tolerance has decreased as they have received treatment while incarcerated.

- **And the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women**, distributing six awards that total up to \$5.4 million: This program enhances flexibility in the use of funds designed to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of an SUD, including OUDs; 2) help state substance abuse agencies address the continuum of care, including services provided to pregnant and postpartum women in non-residential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery.

Anyone in the United States seeking treatment for substance use issues should call SAMHSA's National Helpline at 800-662-HELP (4357) or visit findtreatment.gov. If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat at 988lifeline.org. Anyone who needs help knowing what first step to take in pursuing help can find guidance at findsupport.gov.

HHS Issues Proposed Rule to Advance Non-discrimination in Health and Human Service Programs for LGBTQI+ Community

Proposal reaffirms federal protections against discrimination in HHS grants and makes clear civil rights protections previously restricted

ON JULY 11, the Department of Health and Human Services (HHS) through the Office for Civil Rights (OCR) and the Assistant Secretary for Financial Resources (ASFR) announced a Notice of Proposed Rulemaking (NPRM) to affirm civil rights and equal opportunity for people nationwide in HHS funded programs and services. The proposed rule, *Health and Human Services Grants Regulation* (HHS Grants Rule), if finalized, would protect LGBTQI+ people from discrimination in important health and human services programs by clarifying and reaffirming the prohibition on discrimination on the basis of sexual orientation and gender identity in certain statutes. This NPRM further builds on HHS' efforts to ensure **access to health and human services in furtherance of** President Biden's Executive Orders on Preventing and Combating Discrimination on the Basis of Gender Identity and Sexual Orientation and Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals.

"People should be able to access health and human services without bias, discrimination, or fear," said HHS Secretary Xavier Becerra. "Today's proposed rulemaking will help to ensure quality, accessible health and human services for LGBTQI+ Americans across the country delivering on our commitment to advance equality for LGBTQI+ Americans."

"Today's proposed rule is another important step in restoring the civil rights infrastructure at HHS, which is needed more than ever for our LGBTQI+ community," said OCR Director Melanie Fontes Rainer. "When individuals seek care and services from HHS in our programs and activities, they should not have to fear being discriminated against because of who they are or who they love."

The proposed HHS Grants Rule, if finalized, would clarify and reaffirm the prohibition on discrimination on the basis of sexual orientation and gender identity in federal statutes administered by HHS, consistent with the Supreme Court's decision in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020). The proposed rule would confirm non-discrimination

protections in HHS programs, including Head Start, as well as services and grants that provide aid to refugees, assistance to people experiencing homelessness, substance abuse treatment and prevention, community mental health services, maternal and child health services, and community services. The proposed HHS Grants Rule also includes a provision that ensures that those with religious objections may seek an exemption from or modification of program requirements, as appropriate. HHS encourages all stakeholders, including individuals and their families, health insurance issuers, health care providers, health care professional associations, consumer advocates, and state and local government entities, to submit comments through [regulations.gov](https://www.regulations.gov).

Public comments on the NPRM are due 60 days after publication of the NPRM in the Federal Register. The NPRM may be viewed or downloaded at: <https://www.federalregister.gov/public-inspection/2023-14600/health-and-human-services-grants-regulation>.

The proposed HHS Grants Rule is yet another step by HHS in working to improve access to care and social services for the LGBTQI+ community.

- Learn how the HHS Office for Civil Rights protects LGBTQI+ people from discrimination in receiving needed medical care and other services.
- For Providers of Health Care and Social Services: <https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html>.
- Civil Rights for Individuals and Advocates: <https://www.hhs.gov/civil-rights/for-individuals/index.html>.

If you believe that you or someone else has been discriminated against because of your race, color, national origin, disability, age, sex, or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the HHS Office for Civil Rights at: <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>. **HIV**

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SYPHILIS in the United States

A PRACTICAL OVERVIEW FOR HEALTH CARE PROVIDERS

By Chibuzor M. Babalola, MD, MPH; Andy Liu, BS;
and Jeffrey D. Klausner, MD, MPH

Epidemiology

According to the latest surveillance data from the Centers for Disease Control and Prevention (CDC), the national syphilis rate has risen by a staggering 235 percent since 2012 (from 15.9 to 53.2 per 100,000 population).¹

The surge affects all U.S. regions, genders, and ethnic backgrounds. However, the distribution of primary and secondary syphilis in 2021 remained consistent with previous years, with higher prevalence among men who have sex with men (MSM), non-Hispanic American Indian or Alaskan natives, and in the western region of the country.^{1,2}

NOTABLY, SYPHILIS IS ESCALATING IN WOMEN OF REPRODUCTIVE AGE.^{1,2} Rates of primary and secondary syphilis in this group have risen more sharply, resulting in a decline in the male-to-female case ratio, from 10.2 in 2012 to 3.5 in 2021. This trend is worrisome, as it parallels an eight-fold increase in reported congenital syphilis cases since 2012, climbing from 344 total cases to 2,855 in 2021.^{1,2}

Among the 2,855 reported cases of congenital syphilis, approximately one in 12 resulted in stillbirth or infant death.^{1,2} Nevertheless, this statistic fails to fully capture the morbidity from untreated syphilis during pregnancy, which includes fetal loss as high as 40 percent, and infants born with prematurity, low birth weight, birth defects, neurologic impairment, or other adverse outcomes.^{3,4}

The main contributing factors to increases in congenital syphilis are missed opportunities for testing and treatment.⁵ In 2021, 41 percent of mothers lacked timely prenatal syphilis testing, 34 percent received timely testing but inadequate treatment, and 14 percent first tested reactive in the third trimester.¹ This underscores the importance of heightened vigilance to ensure timely screening and appropriate treatment throughout pregnancy.

Comprehensive prenatal screening could cut missed prevention chances by 75 percent.⁶ Alongside early prenatal testing, serologic screening at 28 weeks and during delivery is recommended for higher-risk women, per the CDC, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists guidelines.^{7,8} Third-trimester syphilis screening is now mandated in seventeen states and the District of Columbia.

Diagnosing Syphilis

Completing the testing-to-treatment cascade is essential for effective management. Standard laboratory-based tests are routinely available, and clinicians should consider the context when choosing between traditional laboratory-based syphilis testing (nontreponemal screening followed by treponemal test confirmation) or the reverse testing algorithm, using a treponemal test first.⁹

Automated treponemal immunoassays have facilitated testing by requiring less staff time enabling faster results and excluding further testing if the initial test result is negative. However, the reverse algorithm may pose challenges in about 30 percent of instances when the initial test is reactive but the reflex nontreponemal rapid plasma reagin (RPR) is not reactive.¹⁰ In such discordant cases, a second treponemal assay like the manual *Treponema pallidum* particle agglutination is recommended to determine if the first treponemal assay was a false positive or if the patient is in the very early window period of infection when the RPR has not yet become reactive.⁷ Understanding the timing of serologic response, along with the patient's clinical and testing history, can guide the clinician's choice of testing algorithm. The **figure** highlights the earlier rise and persistence of treponemal antibodies compared to non-treponemal antibodies that tend to wane over time.¹¹

Rapid Point-of-Care Testing

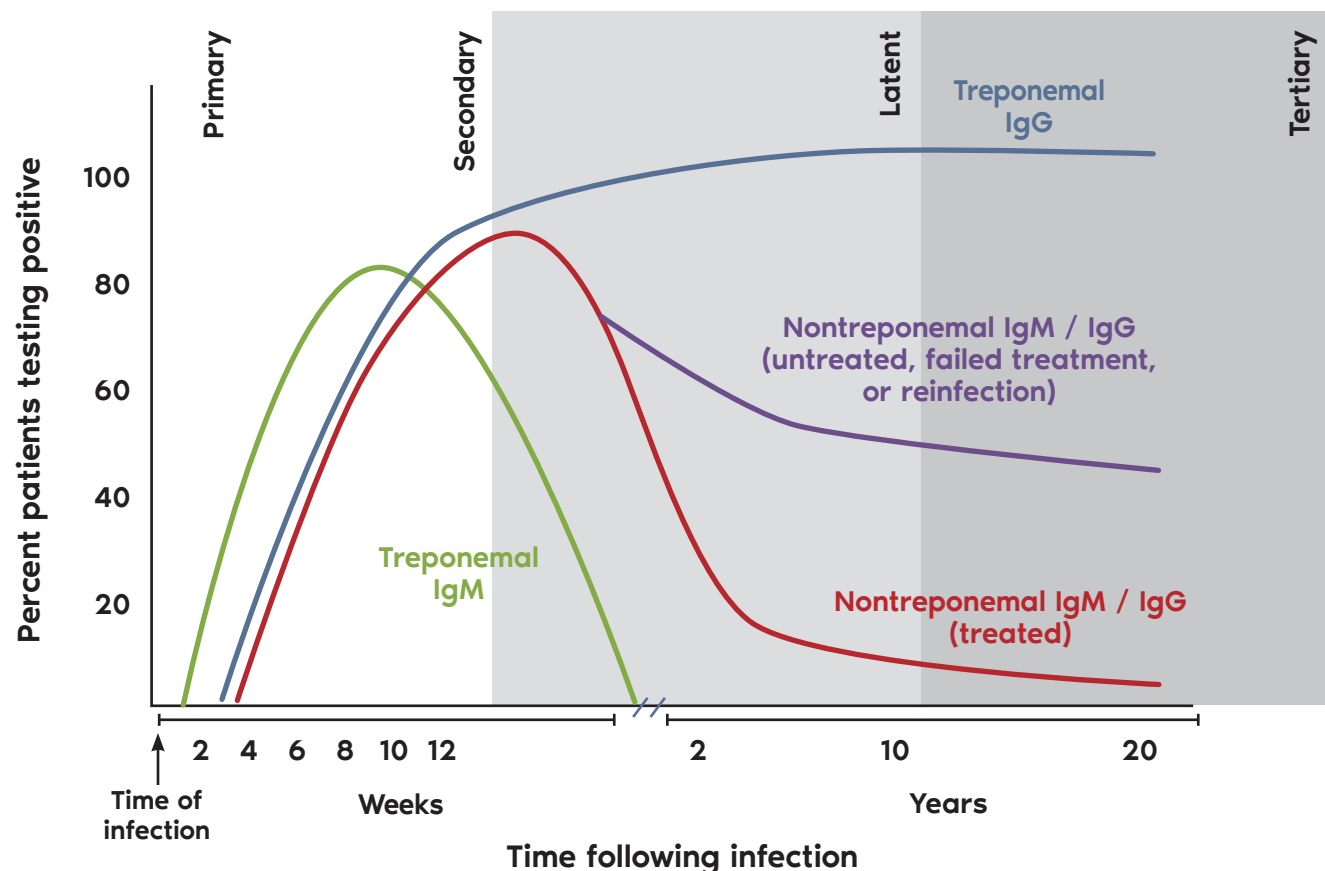
The 2021 CDC report further advocates increased use of rapid and point-of-care tests to close syphilis testing-to-treatment gaps.¹ Two Food and Drug Administration (FDA)-cleared and Clinical Laboratory Improvement Amendments (CLIA)-waived point-of-care treponemal tests have demonstrated very good performance (**see table**). The first, called the Syphilis Health Check and manufactured by Diagnostic Direct LLC (New Jersey), received a CLIA waiver in

Table. Characteristics of the FDA-cleared, CLIA-waived Rapid Point-of-Care Treponemal Tests

Test	Time to Results	Specimen	Sensitivity	Specificity
Syphilis Health Check ¹²	10 minutes	fingerstick whole blood (direct patient contact)	98.0% (95%CI: 95.0-99.2)	97.2% (95%CI: 94.0-98.7)
Dual Path Platform (DPP) HIV/Syphilis Assay ¹⁴	10-25 minutes		94.7% (95%CI: 89.0-97.6)	95.5% (95%CI: 94.2-96.6)

Test performance data are as indicated in package inserts.

Figure. Treponemal and Nontreponemal Antibodies Across Stages of Syphilis Infection: Expected Trends in Serologic Response



From: Soreng K, Levy R, Fakile Y. Serologic Testing for Syphilis: Benefits and Challenges of a Reverse Algorithm. *Clin Microbiol News*. 2014;36(24):195-202. doi:10.1016/j.clinmicnews.2014.12.001

December 2014 and has been evaluated in multiple laboratory and clinical settings in the U.S.^{12,13} Using lateral flow, this device produces a pink-colored display band within 10 minutes of introducing a drop of fingerstick whole blood, venous whole blood, serum, or plasma into a single-use cassette, indicating a reactive result. The second test, developed by Chembio Diagnostics, Inc. (Medford, New York), is called the dual path platform (DPP) HIV/Syphilis.^{14,15} The DPP test recently received its CLIA waiver in February 2023. It allows for simultaneous HIV and treponemal antibody detection, making it potentially valuable for populations in need of syphilis testing without known HIV-infection status. The DPP test involves more steps and employs an electronic reader to deliver results in 10 to 25 minutes.¹⁴

A comprehensive evaluation of the Syphilis Health Check across syphilis testing sites in Florida and a field assessment of the DPP HIV/Syphilis in an emergency setting in Baltimore reported high acceptability of the respective tests among patients.^{16,17} An additional assessment among providers who used the Syphilis Health Check in the

Florida study revealed their satisfaction with the shorter time to treatment and increased partner testing facilitated by the test.¹⁶

Rapid point-of-care tests could offer significant advantages in situations where patients might not promptly return for results, are challenging to reach, or lack recent prior testing. That is, situations where timely diagnosis and potential treatment are critical. Pregnant women and individuals with ongoing syphilis exposure may be suitable populations for the use of these rapid tests.

Importantly, like the recommendation for not repeating HIV antibody testing in individuals with known HIV infection, rapid treponemal testing should only be conducted in those without a history of syphilis

The syphilis epidemic in the U.S. is a multifaceted challenge and congenital syphilis presents a unique concern.



or syphilis treatment. After treatment, treponemal antibodies will remain detectable in up to 85 percent of cases.¹¹ There is no value in documenting persistent treponemal antibodies in persons who are already known to be treponemal antibody positive. To screen patients with a history of syphilis, non-treponemal testing is required, such as the use of the RPR or Venereal Disease Research Laboratory test.

Prevention

Consistent condom use remains the mainstay of sexual health and prevention of sexually transmitted infections (STIs). While a safe and effective syphilis vaccine would be the ideal, a commercially available one may be at least 10 years away.

In the meantime, doxycycline post-exposure prophylaxis for *Chlamydia trachomatis*, *Neisseria gonorrhoeae* and syphilis has proven to be efficacious in a recent study and is increasingly recommended in sexually active MSM, transwomen, and others who have frequent bacterial STIs.^{18,19} That study recorded a reduction in the incidence of syphilis by 77 percent among participants with HIV and by 87 percent in those without HIV infection.¹⁸ The recommended dose is doxycycline 200 mg within 72 hours of a sexual contact.

It's crucial to recognize that the rise in syphilis and other STIs coincides with issues like HIV, substance use, and viral hepatitis in heavily affected groups.²⁰ Socio-economic factors such as poverty, homelessness, limited health care access, and stigma further exacerbate the disease burden.^{5,21} Hence, the CDC and public health experts stress the importance of adopting a comprehensive strategy to counter the epidemic.^{20,22,23} This syndemic approach considers the intricate interplay of factors that, if ignored, could greatly hinder prevention efforts.

Treatment

For the management of primary, secondary, or latent syphilis lasting less than one year, the recommended therapy is a single intramuscular dose of benzathine penicillin G, 2.4 million units. This treatment is also considered sufficient for people living with HIV, as per CDC guidelines.⁷ In cases of penicillin allergy or unavailability, clinicians may opt for twice-daily doxycycline 100 mg for 14 days. However, benzathine penicillin remains the recommended choice during pregnancy and should be administered after desensitization in individuals with proven penicillin allergy.⁷

Due to the declining availability of benzathine penicillin G, researchers are investigating alternative treatments, such as oral cefixime 400mg twice a day, and linezolid 600mg twice a day.^{22,23} Preliminary trial findings for cefixime are promising, showing similar efficacy to benzathine penicillin at three and six months after treatment.²⁴ Maternal and drug safety experts should consider exploring the efficacy of cefixime or linezolid in pregnant individuals, given the limited data on potential harm.

The latest CDC STI Treatment Guidelines clarified the indications for cerebrospinal fluid analysis in individuals with syphilis as only

necessary for those with clinical symptoms of possible neurosyphilis.⁷ Cerebrospinal fluid analysis is not recommended for those with only visual or auditory abnormalities, as 14-days of intravenous penicillin G therapy is advised irrespective of the cerebrospinal fluid analysis results.⁷ The CDC still recommends an additional one to three weekly doses of benzathine penicillin G after the completion of intravenous therapy for all forms of neurosyphilis.

Conclusion

The syphilis epidemic in the U.S. is a multifaceted challenge and congenital syphilis presents a unique concern. Vital to prevention efforts are routine testing—including rapid testing—and timely treatment. New prevention strategies like doxycycline STI post-exposure prophylaxis are promising. Ultimately, addressing social determinants of health and responding to syndemics of opiate use, poverty, and lack of housing, will be crucial to reduce the conditions facilitating continued syphilis transmission and lead to a community of wellness and improved sexual health. **HIV**

Key points

- Syphilis cases in the U.S. have increased by 235 percent since 2012.
- The concurrent eight-fold increase in cases of congenital syphilis further raises concerns.
- Available rapid point-of-care tests bridge gaps in timelier diagnosis and treatment.
- A syndemic approach to prevention and control is advised.



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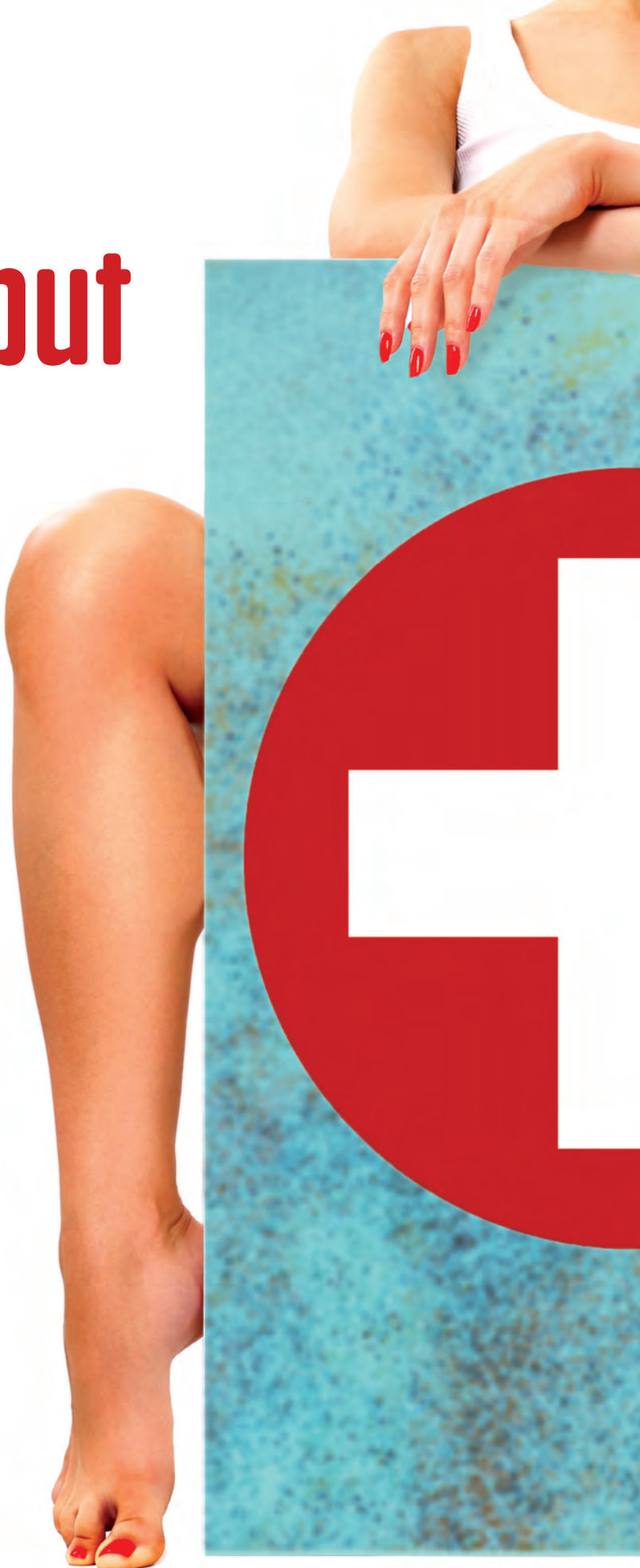
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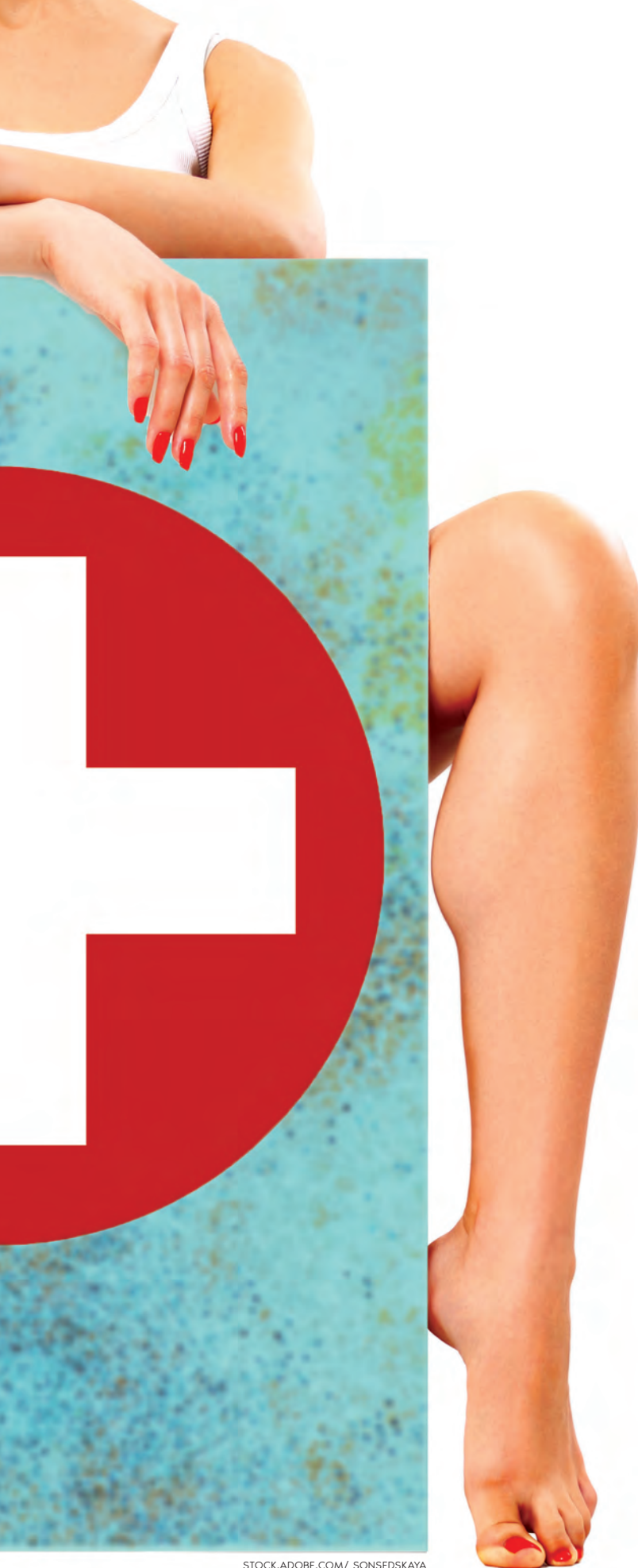
Trichomonas vaginalis among Cisgender Women with HIV—A Pathogen to Know

By Bernice D. Kear, BS, MS;
Maria F. Rojas, BA; and
William R. Short, MD, MPH, AAHIVS

CASE PRESENTATION

A 34-year-old cisgendered female with a history of well-controlled HIV presents to clinic for a routine follow-up visit. She has routine labs done, including her annual screening for Trichomoniasis and the results are positive. How would you assess and create a plan for this patient?





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Introduction and Epidemiology of Trichomoniasis

Trichomoniasis (TV) is a highly prevalent sexually transmitted infection (STI) caused by the protozoan *Trichomonas vaginalis* (*T. vaginalis*), and is more common than chlamydia, gonorrhea, and syphilis.^{1,2,3} TV infection exhibits distinct epidemiological patterns between males and females. In women, TV is often symptomatic, whereas men tend to present asymptotically. This difference in presentation contributes to challenges in diagnosing and effectively treating TV in men as well as preventing transmission between sexual partners.^{3,4}

According to the World Health Organization, in 2016, an estimated 156 million new cases of TV were reported worldwide among individuals 15 to 49 years old.⁵ Notably, these rates may be underestimated due to under-surveillance and utilization of less sensitive testing techniques; variations in prevalence are also seen across different populations and geographic regions.³ TV remains a major public health concern due to associated adverse health outcomes, particularly in communities facing health disparities. Recent breakthroughs in the global epidemiology have transformed the diagnosis, treatment, and management of TV. These include highly sensitive diagnostic techniques and an enhanced understanding of the clinical attributes of TV among differing populations.²

A meta-analysis by Masha et al., investigated the relationship between TV and HIV acquisition and found that patients with TV had a 50 percent higher risk of acquiring HIV compared to those without TV infection.⁶ The potential impact of TV on the spread of HIV is considerable given its high prevalence, particularly in sub-Saharan Africa. Thus, there is a need to approach TV treatment as a preventative measure in reducing HIV transmission, particularly in high-prevalence regions, and improving public health outcomes by reducing the burden of HIV.

Pathogenesis of TV

T. vaginalis is a parasitic protozoan that infects the genitourinary tract epithelium; it is an extracellular pathogen that adheres to host cells during infection, which is crucial for its survival (**Figure 1**). The parasite is considerable in size and contains six chromosomes that code for approximately 60,000 genes.³ It obtains nutrients by lysing and feeding off host cells through surface molecules, such as lipoglycan.⁷ The incubation period for TV typically ranges from four to 28 days. In women, TV inhabits the lower genital tract, whereas in men, it can be found in the urethra and prostate. In these locations, the parasite undergoes reproduction through binary fission.³ The parasite uses proteins to invade hosts successfully, attaching via adhesion proteins and receptors.⁸ It relies on host erythrocytes for lipids and iron and facilitates hemolysis through specific proteins; hemolytic activity correlates with its virulence, and an abundance of proteinases contributes to its pathogenesis.⁸

The parasite is able to evade the host immune system through multiple strategies. It activates complement in low-complement environments, uses iron to resist destruction, undergoes phenotypic variation to avoid immune recognition, degrades immunoglobulins, secretes immunogenic antigens, and coats itself with host proteins to evade detection.⁸

Transmission and Clinical Manifestation

TV is primarily transmitted through sexual intercourse, as humans are its exclusive host.⁸ In women, infection can persist for prolonged periods, potentially lasting months to years. However, in men, it

typically resolves within ten days.^{2,3,4} While non-sexual transmission of TV through objects and potentially water was once thought to be uncommon, there is evidence indicating its plausibility.^{3,8}

Incidence of asymptomatic infection is greater in men, though the parasite burden is greater in women.^{7,9} Symptomatic women most commonly present with symptoms of vaginitis, including the presence of frothy yellow-green vaginal discharge, vulvovaginal irritation, and vaginal odor. Additional clinical manifestations of *T. vaginalis* infection include genital pruritus, dysuria, dyspareunia, and fallopian tube pathology.^{1,9} Physical examination may reveal a strawberry-like appearance (“colpitis macularis”) of the cervix with notable discharge characteristic of TV in the vaginal vault.⁹ Untreated *T. vaginalis* infections in women with HIV may result in long-term sequelae, such as pelvic inflammatory disease, poor birth outcomes, and infertility.^{9,10}

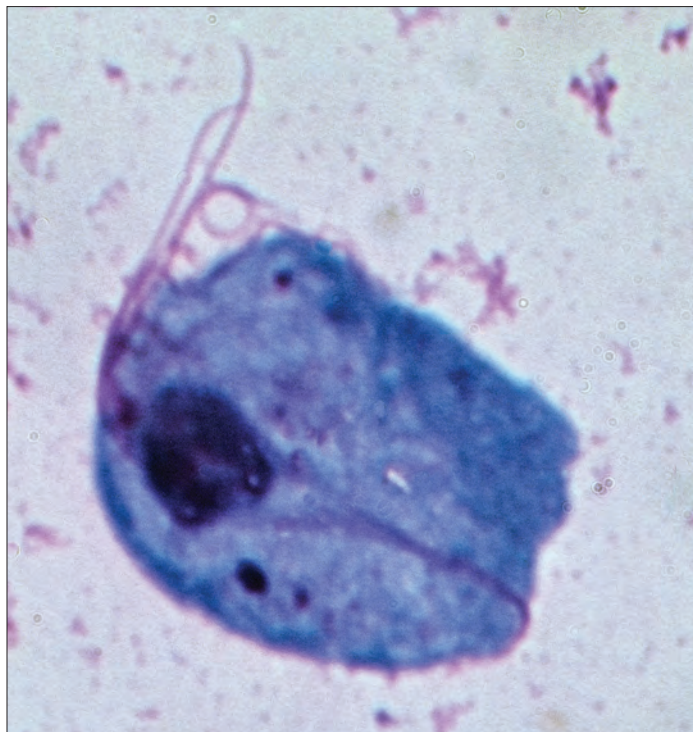
Women with HIV may experience more persistent TV infections, potentially attributed to compromised immune function. Moreover, a meta-analysis revealed a 1.5-fold increased likelihood of acquiring HIV in individuals with *T. vaginalis* infection compared to those without it.⁶ TV can cause genital inflammation, ulcerations, and genital shedding of HIV.⁶ These findings underscore the importance of addressing *T. vaginalis* infection in HIV prevention and management strategies.

Diagnosis

T. vaginalis infection can be detected by several diagnostic tests (**See Table 1**). The most common point-of-care (POC) method is by wet mount microscopy of vaginal secretions. In this method, motile trichomonads can be visualized on a wet mount slide (**Figure 2**). Although its sensitivity is low (44%–68%), its specificity is high (100%).⁹ This test should be performed within 20 minutes of specimen collection, as trichomonads lose viability with time, increasing the risk of false negatives.⁹

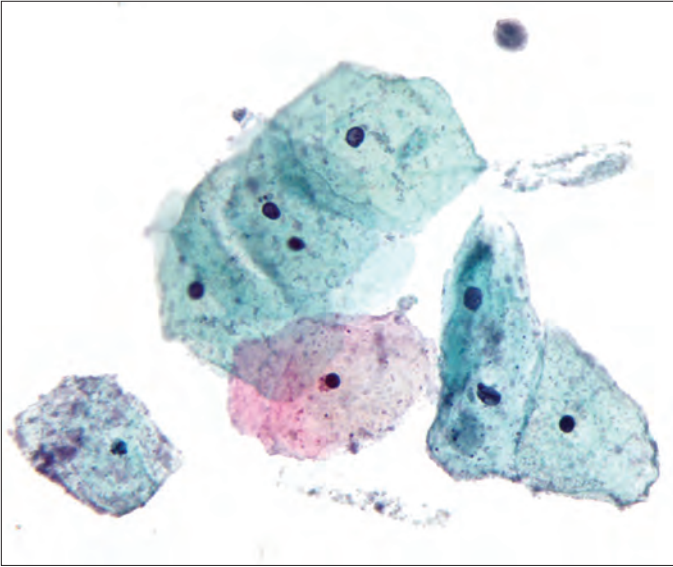
In the past, culture was the gold standard for *T. vaginalis* detection, offering moderate sensitivity (44%–81%) and high specificity (100%).^{9,10} However, its limitations include the need for suitable medium, immediate

*Figure 1: The parasitic protozoan, *T. vaginalis*



Nephron, CC BY-SA 3.0 <<https://creativecommons.org/licenses/by-sa/3.0/>>, via Wikimedia Commons

*Figure 2: *T. vaginalis* under wet mount microscopy



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inoculation, multiple readings, and on-site microscopy. Nevertheless, culture remains valuable in assessing resistance in positive specimens, particularly in recurrent infections.⁹

In recent years, the OSOM rapid test (Sekisui Diagnostics, California) has transformed TV diagnosis, employing antibodies to detect *T. vaginalis*-specific proteins in vaginal secretions without a microscope. It's highly sensitive (82%–95%) and specific (97%), but recommended for symptomatic women or those recently exposed to *T. vaginalis*.⁹

Currently, nucleic acid amplification tests (NAATs) are recommended for detecting TV. These highly specific (98%–100%) assays detect amplified target RNA. The only FDA-cleared NAAT for *T. vaginalis* is the Aptima *Trichomonas vaginalis* assay from vaginal, endocervical, or urine specimens, and has a sensitivity of 88 to 100 percent.^{9,10}

Management and Treatment

The Centers for Disease Control and Prevention (CDC) treatment guidelines recommend that women with and without HIV be treated for *T. vaginalis* infection with metronidazole (MTZ); however, the dosing frequencies differ.¹¹ This recommendation was the result of data from a randomized clinical trial involving women with HIV, which demonstrated that a single 2g oral dose of MTZ was less effective than a regimen of oral 500mg MTZ twice daily for seven days.¹² Women randomly assigned to oral 500mg MTZ twice daily for seven days were significantly less likely to retest positive for *T. vaginalis* on culture at the six to 12 day test-of-cure (TOC) visit (8.5% vs. 16.8%; relative risk 0.5, CI 0.26-1.00) and the three-month visit (11% vs. 24.1%; relative risk 0.46, CI 0.21-0.98) compared to those on single-dose therapy.¹² Other factors that could have contributed to poorer outcomes among women that received the single dose include co-infection with bacterial vaginosis (BV), with an incidence of 66.8 percent among HIV+/TV+ women, and unique vaginal microbiota.^{13,14}

According to the CDC, women with HIV should be routinely screened for *T. vaginalis* infection at entry of care and annually thereafter. Furthermore, it's recommended that women with HIV be retested for TV within three months of treatment due to high reinfection rates.^{11,15}

Table 1. Diagnostic Tests for *T. vaginalis* in Women

TEST	Wet mount microscopy	InPouch <i>T. vaginalis</i> culture system	OSOM rapid test	Aptima <i>T. vaginalis</i> assay (NAAT)
POPULATION	Women	Men and women	Symptomatic women	Women
SPECIMEN TYPE	Vaginal secretions	Vaginal secretions	Vaginal secretions	Endocervical, vaginal, urine, and pap specimens
SENSITIVITY	44%–68%	75%–96%	82%–95%	88%–100%
SPECIFICITY	100%	100%	97%–100%	98%–100%
TIME TO RESULTS	<10 min (POC)	5–7 days	<10 min (POC)	5.5 hrs

Adapted from Van Gerwen et. al, 2023. —Trichomoniasis (9)

In the context of examining the impact of race on TV, a recent study by Getaneh et al. observed decreased retesting rates within three months of treatment among patients identifying as non-Hispanic Black, drawing light to disparities in TV management.¹⁶ Understanding and addressing these disparities are paramount for clinicians to ensure equitable and comprehensive care for all patients.¹¹

Implications of TV and HIV Co-Infection

The co-occurrence of HIV and TV has several implications for health outcomes. The observed increased incidence of TV among women with HIV may be attributed to several pathogenic mechanisms of *T. vaginalis*. Firstly, it can disrupt the protective epithelial membrane, which serves as a barrier to HIV, through mechanisms such as cell-to-cell adhesion, hemolysis, and secretion of soluble factors. Secondly, *T. vaginalis* can trigger an inflammatory response in infected individuals, potentially leading to an increase in HIV target cells. Lastly, *T. vaginalis* infection has been linked to BV, which can further augment the risk of acquiring HIV.⁶ TV has also been associated with increased genital HIV shedding, a process critical for HIV transmission. Collectively, these factors may contribute to an environment that facilitates HIV transmission in individuals infected with *T. vaginalis*.⁶

The mechanistic interplay between TV and HIV also has an impact on the treatment of both infections. After observing that repeat TV

infections were particularly high among women with HIV, Kissinger and Adamski et. al. performed a secondary analysis of the clinical trial data to elucidate contributing factors; their data suggest an association between *T. vaginalis* infection and antiretroviral therapy (ART) independent of BV infection, in which women receiving ART were 4.58 times more likely to be TV-positive at TOC than women not receiving ART.^{12,17} While the treatment of HIV may interfere with the clearance of TV, effective treatment of TV in women with HIV may decrease transmission of HIV. In a study conducted on the impact of effective TV treatment on vaginal HIV-1 RNA, it was found that women successfully treated for TV were less likely to shed HIV vaginally at three months post-treatment compared to baseline (R.R. 0.34, 95% CI: 0.12–0.92), whereas no change was detected for TV-negative women.¹⁸ This data further support the idea that the pathogenesis of TV and HIV are interconnected.



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TV in Pregnancy

TV also impacts pregnancy outcomes for women with HIV. Aside from its association with increased vaginal shedding, further increasing the risk of vertical transmission via vaginal delivery, infection with *T. vaginalis* has been associated with preterm delivery, prelabor rupture of membranes (PLRM), and delivery of low birth weight infants.¹⁹ TV-induced inflammation has been suggested as a potential mechanism for adverse birth outcomes. It is believed that this inflammation can lead to premature cervical ripening, increasing the risk of preterm birth and PLRM. Additionally, intrauterine inflammation caused by TV infection may disrupt placental blood flow, further impacting fetal well-being.^{20,21}

Conclusion

TV is the most common treatable STI and has a significant burden among women with HIV. Co-infection of HIV and *T. vaginalis* has implications that can contribute to poor health outcomes. To mitigate the adverse effects associated with asymptomatic or untreated TV, clinicians must be familiar with the prevalence, presentation, and effective treatment of TV among women with HIV to address this public health concern. **HIV**

CASE RESOLUTION

The patient was prescribed a regimen of oral 500 mg metronidazole (MTZ) twice daily for seven days. A follow-up visit was scheduled for monitoring treatment response, side effects, and ongoing management of both infections.



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ADDRESSING Barriers and IMPROVING Sexual Health

TOOLS FOR PROVIDERS AND PATIENTS

By Alexis Osei, MPH; Megan Higdon, MPH; Susan Gilbert, MPA

GOOD SEXUAL HEALTH is much more than disease prevention and risk reduction. And the public agrees. The National Coalition for Sexual Health (NCSH) conducted research with Americans ages 18 to 70 and they embraced NCSH's positive, comprehensive definition of sexual health: "Being sexually healthy means being able to enjoy a healthier body, positive relationships, a satisfying sexual life, and peace of mind."¹

Barriers Stand in the Way of Sexual Health

While Americans are eager to improve their sexual health, they describe many challenges to doing so, including advocating for and valuing themselves; choosing partners who treat them well; building positive relationships; and communicating openly about sex and sexual health with partners, family members, and health care providers. During NCSH focus groups, members of the public brought these obstacles to life.¹

"If there's no honesty, there's no relationship." (man, age 18–29)

"You must feel good about yourself and have peace of mind in order to have good relationships." (woman, age 60–70)

"Respect is huge, this incorporates many components such as respecting boundaries and desires." (man, age 30–39)

"People not talking about sex is huge." (woman, age 40–59)

"Can't have good sex without having good peace of mind." (man, age 18–29)

"It has to be 50/50, one person should not have the upper hand." (man, age 18–29)



At the same time, we recognize that numerous factors—beyond the individual level—also shape our sexual health, including the conditions in which we are born, live, work, grow, and play. And, for many people, social determinants of health, such as poverty, poor housing, lack of access to health care, and discrimination, are significant. As a result, certain communities are more vulnerable to poor sexual health, including teens, young adults, people who are LGBTQ, and specific racial and ethnic groups.

A Practical Framework to Improve Sexual Health

To help reduce sexually transmitted infections (STIs), HIV, and other sexual health problems and promote well-being, we believe it is essential to address the key barriers reported by the public. In turn, the NCSH created the Five Action Steps to Good Sexual Health, which include: 1) Value who you are and decide what is right for you; 2) Get smart about your body and protect it; 3) Treat your partners well and expect them to treat you well; 4) Build positive relationships; and 5) Make sexual health part of your health care routine. These action

steps, which include practical advice, tips, and conversation starters, can be found at www.fiveactionsteps.org.

A Focus on Delivering Sexual Health Care Services

Since health care providers are the primary audience for this article, we will focus on step five: Make sexual health part of your health care routine. It's clear from the data that many Americans are not benefiting from recommended preventive sexual health services that can protect their health and even save their lives. For example, only 44.1 percent to 54.4 percent of sexually active women ages 24 and younger were screened for chlamydia and gonorrhea, even though it is recommended annually; although HIV

ADDRESSING BARRIERS AND IMPROVING SEXUAL HEALTH

testing is recommended for everyone at least once, only 43 percent have ever been tested; unplanned pregnancies still account for 45 percent of all pregnancies, while 23 percent of women and nine percent of men reported no contraceptive use at first sex; and, sexual difficulties are common, being experienced by at least 43 percent of women and 31 percent of men.^{2,3,4}

STI rates in the U.S. continue to rise, and many STIs are asymptomatic in nature, which, without regular screening, increases the likelihood of missed opportunities to provide health-promoting and life-saving care. Obtaining a comprehensive sexual history for patients allows providers to assess any behavioral risks, suggest appropriate testing and services, and provide counseling and education.

One of the primary reasons we are coming up short when it comes to delivering these services and promoting harm-reduction behaviors is that many providers are not routinely taking sexual histories. As sexual health is linked to overall health, it is particularly important that comprehensive sexual histories are collected as part of routine care for patients across the lifespan.

Although 71.8 percent of providers self-report that they include comprehensive sexual history taking as part of regular clinical practice, chart reviews indicate that patients who had a sexual history taken during a well visit or annual visit ranged only from 21 percent to 30 percent. Furthermore, the likelihood of a provider taking a comprehensive sexual history decreases when the patient and the provider are not sex concordant.⁵

Provider bias can also result in missed opportunities. Assumptions based on sex, age, race, gender identity, or sexual orientation impact the likelihood of a provider taking a comprehensive sexual history. For example, studies show that providers are more likely to take a comprehensive sexual history from older adolescents versus younger adolescents. Similarly, women are more likely to have comprehensive sexual histories taken versus men, and Black patients are more likely than any other race to have a comprehensive sexual history taken.⁵

It also is vital that providers practice inclusive and trauma-informed care as they

gather comprehensive sexual histories from patients. Taking a universal precautions approach (i.e., approaching all patients as if they may have experienced trauma) reduces the risk of any re-traumatization during sexual history taking by making small adjustments to language or behaviors to increase patient comfort, well-being, and control. Adopting a trauma-informed approach during routine visits can improve patient engagement, decision making, and health outcomes.⁶

Primary Barriers to Sexual Health Conversations and the Delivery of Services

For health care providers, starting conversations with patients around their sexual history can provide significant challenges in clinic. While the lack of time available within the patient's visit is most often reported as the reason for not reviewing sexual history, many providers report discomfort with talking about sexual health with patients as the main barrier, specifying that asking about specific sexual practices and not wanting to offend patients contributes to that discomfort.

Similarly, the public face many barriers to getting the sexual health care services they want and need. Given the pervasive stigma and discomfort surrounding sexual health conversations, it is no surprise that many patients are reluctant to talk openly with providers about this topic. And some patients expect providers to take the lead and are waiting for them to do so. Others in our focus groups shared that they lacked knowledge about which preventive sexual health services are recommended for them, and/or assumed that providers would automatically give them what they need. The quotes below represent these public perceptions (and are drawn from focus groups to test the NCSH guide, "Take Charge of Your Sexual Health").⁷

"If you don't bring it up, they won't do so. I can barely get them to listen to me about acid reflux." (man, age 20–30)

"When I get my Pap test, there were a whole bunch of q-tips. They must be testing me for lots of things." (woman, age 30–39)

"I'm surprised by the number of tests recommended." (man, age 30–39)

Participants responded very favorably to the guide, saying that it provided a lot of helpful information and encouraged them to take action themselves. Also, they strongly embraced the concepts of making sexual health care a priority, normalizing conversations, and making services part of routine care, such as STI testing. As one participant said, "Making sexual health normal would be revolutionary for our society." (*man, age 30–39*)

Practical, Evidence-Based Tools for Providers and the Public

Routine comprehensive sexual history taking helps to ensure that patients have the best health outcomes possible. To address both provider and patient barriers around having these conversations, NCSH has developed many practical, streamlined resources for personal use or to use in clinic. These tools are designed to empower and equip providers and the public to have these conversations and access the services they want and need more easily. These free resources, which are described in the sidebar on page 27, are evidence-based, underwent professional review, and were message tested with the public. All resources are available through the NCSH website at www.nationalcoalitionforsexualhealth.org. **HIV**



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SUSAN GILBERT, MPA, is Co-Director of the National Coalition for Sexual Health (NCSH) that is comprised of over 230 members dedicated to improving the sexual health and well-being of people across the lifespan. Susan leads NCSH's Communications Action Group, pioneered a new sexual health definition and the "Five Action Steps to Good Sexual Health," and directs media outreach. Susan creates health communication campaigns and coalitions in the U.S. and internationally to promote sexual health, HIV prevention, and family planning. Previously, as Senior Vice President at Ogilvy Public Relations, she directed health communication campaigns for clients including the CDC and USAID. While living in Africa for eight years, Susan developed sexual health and HIV prevention, care, and treatment campaigns for Population Services International, Johns Hopkins University, and Columbia University.

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TOOLS FOR PROVIDERS

Inclusive Sexual Health Services: Practical Guidelines for Providers & Clinics

This resource was developed to assist providers and health clinics in establishing an environment that fosters the delivery of sexual health services that are inclusive, patient-centered, and accessible.

Clinician Guide for Trauma-Informed Care

This resource is intended for providers seeking to provide trauma-informed physical examinations in sexual and reproductive health settings.

Sexual Health Questions to Ask All Patients

This tool, which includes the six Ps, helps providers initiate conversations about sexual health, streamline sexual history taking, improve care for LGBTQ patients, and answer patient questions.

Sexual Health and Your Patients: A Provider's Guide

This guide is intended for providers to use to better integrate sexual health conversations and recommended preventive services into

routine visits with adolescents and adults.

Sexual Health and Your Patients: Pocket Cards

These pocket cards—for adults, for adolescents, and for both—allow health care providers to access essential sexual health questions and preventive service recommendations in a clear and concise format.

Compendium of Sexual and Reproductive Health Resources for Health Care Providers

This resource is a collection of existing resources on sexual and reproductive health topics across the lifespan to help providers improve their clinical skills. It includes webinars and other online trainings that may include CE credits, curricula, toolkits, and implementation guides.

TOOLS FOR PATIENTS

Take Charge of Your Sexual Health: What You Need to Know about Preventive Services

This user-friendly guide features recommended services for people based on anatomy, tips for talking with a health care provider, and resources. For the Spanish-speaking community, a culturally adapted and translated guide is available.

Five Action Steps to Good Sexual Health

This practical roadmap helps patients improve their sexual health by taking five key steps. It includes practical tips, information, and conversation starters on advocating for oneself, protecting one's body, treating partners well, building positive relationships, and getting sexual health care services.

Guide to Sexual Concerns & Pleasure

This guide focuses on common sexual concerns that can stand in the way of pleasure. It provides practical solutions, tips on finding a professional who can help, and

scripts for talking with a health care provider or therapist.

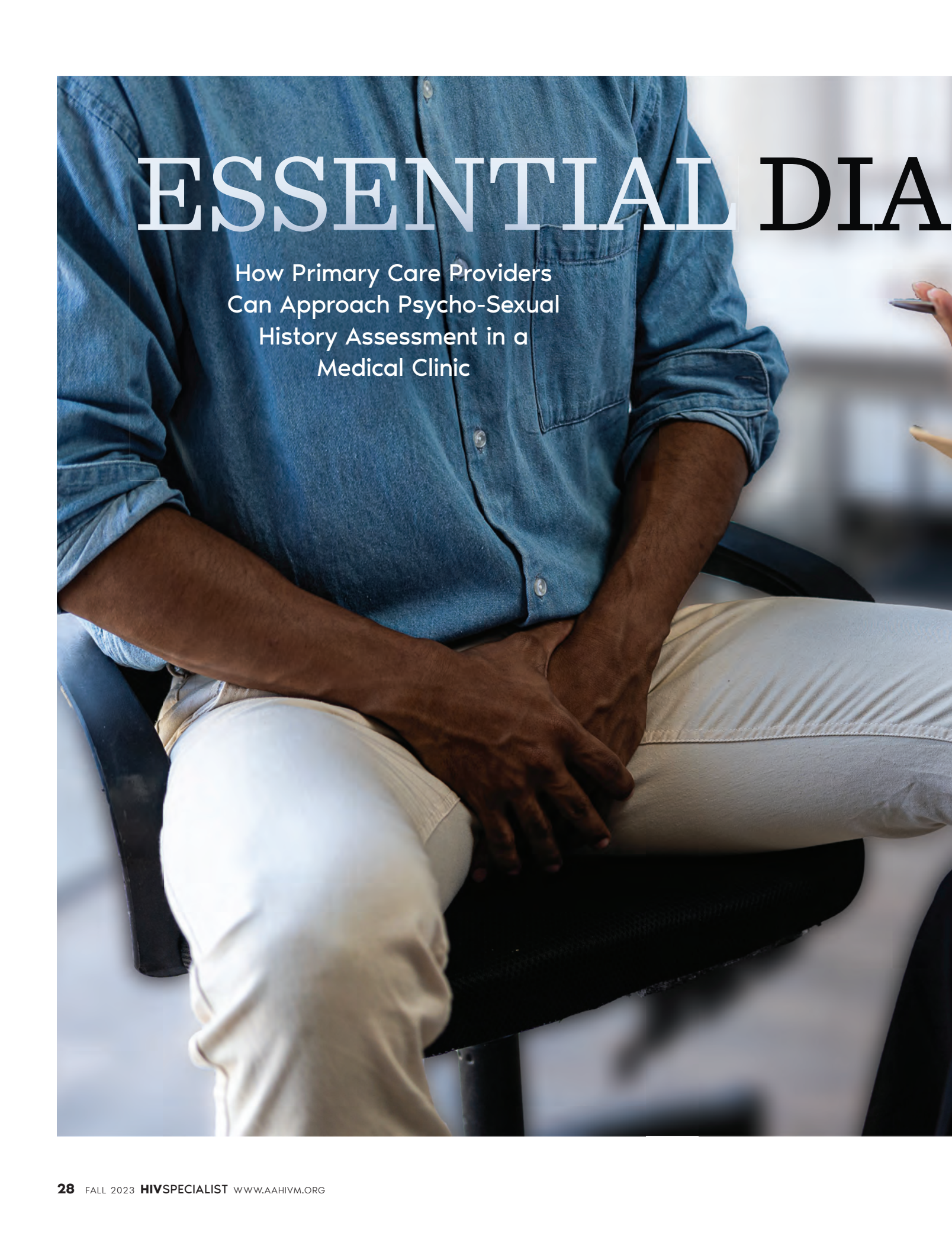
Sexual Health Quick Tips

These colorful graphics provide tips on healthy relationships, consent, body image, safer sex, talking about sexual desires, and advocating for oneself.

Chlamydia and Gonorrhea Testing: More Than Just Genitals

This factsheet, developed by NCSH and the National Association of County and City Health Officials (NACCHO), provides information on extragenital testing. It describes who should get tested and why, what to expect, and tips for talking with a health care provider.

All tools are available at nationalcoalitionforsexualhealth.org.



ESSENTIAL DIA

How Primary Care Providers
Can Approach Psycho-Sexual
History Assessment in a
Medical Clinic



LOGUE

AN OVERVIEW

By Lucy Efobi, DNP, APN, FNP-BC, AAHIVS

Introduction

Sexual health as addressed by the World Health Organization is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.

During health assessments, many health care providers do not commonly discuss sexual orientation or gender identity (SO/GI) with patients and, most importantly, many health care facilities have not included a system to collect structured SO/GI data from all patients. Without adequate SO/GI data, lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients and their specific health care needs cannot be properly identified, the health disparities they experience cannot be addressed, and important health care services may be delayed or neglected. A psycho-sexual history assessment should be taken as part of a routine health care exam, and also when there are signs or symptoms of physical exam findings indicative of a sexually transmitted infection (STI).

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Why Taking a Sexual Health History is Important

Psycho-sexual history taking is a crucial element of one's overall health and well-being that health care providers and their patients should often discuss during routine medical exam or physical exam visits. Most often, discussing a patient's sexual health requires a great deal of trust in the patient-provider relationship. Sexual health should be just as important as any other medical history assessment that is being discussed during a medical consultation. Providers should consider addressing matters like exposure to STIs in a way that puts patients at ease and lessens their embarrassment. Likewise, providers should foster a good clinical plan of sexual health management without being embarrassed themselves, especially when a patient is concerned about things that are outside a provider's experience or comfort level.

Not only is taking a sexual history important in support of a patient's overall well-being, but also is it extremely important today in light of the increases in STIs. The Centers for Disease Control and Prevention's (CDC) report titled "Sexually Transmitted Disease Surveillance, 2021" provides the most current and complete data for nationally notifiable STIs. The report showed that chlamydia, gonorrhea, and syphilis continue to increase in the United States, with more than 2.5 million cases that year combined. Consequently, discussing sexual health can do much to help reverse this worrying trend.

Discussing sexual health concerns with adolescent and adult patients may help to break the barriers of stigma around discussing sex and sexual health. Addressing a patient's sexual health during a routine medical visit offers opportunities for screening for and treatment of STIs as well as counselling and sharing information about behaviors that may increase STI risk. Additionally, it helps providers to gain insight on their patients' overall health condition, history, and knowledge level around sexual health. Most importantly, it creates an avenue for a patient-provider relationship that is based on trust and the provider's ability to center the well-being and welfare of the patient.

What Can Be Done

There are many things a provider can do to take an effective and patient-centered sexual history. First, ask your patient what their preferred name is and how they would like to be addressed. At this time, you can also ask them what pronouns they use. That way, you can use the pronouns they share to support the patient's current gender identity. Regarding gender identity, you can incorporate a two-step method into your assessment. First, you can ask them for their sex assigned at birth (female, male, or decline to answer) and then ask them what their current gender identity is (female, male, transgender female, transgender male, gender diverse, additional gender category, or decline to answer). Additionally, when talking about significant relationships in your patient's life, use neutral and inclusive terms such as "partner" or "spouse" (if they indicate that they are married).

Help your patient to feel comfortable by establishing a rapport before asking sensitive questions. During the assessment, be open to your patients' questions and concerns and avoid making assumptions based on sexual health, age, appearance, marital status, or any other factor. Finally, be sure to provide privacy while discussing sensitive issues and request permission to invite an additional person to the exam room, including partners, relatives, caregivers, or your own co-workers. At the same time, ask for partners or caregivers to step out of the room if you feel that the patient would be more open to talking about sexual health matters, such as recent sexual activity, privately.

A provider's awareness of the importance of taking a sexual history is paramount. But equally important is the fact that medical clinics and hospitals must allot sufficient time to allow for sexual health assessments. As well, medical clinics should include space for sexual health assessment with gender identification in their current electronic health record (EHR) system. It should include the patient's name, pronouns, sexual orientation, and gender identity.

The Way Forward

A sexual history is important for all patients to identify those at risk for STIs, including HIV, to guide risk-reduction counseling, and to identify what anatomic sites are suitable for STI screening. The CDC has developed the "five P" approach to guide clinicians in taking a sexual history assessment.

1. Partners

When asking about sexual activity with partners, you can ask patients whether they are currently having sex of any kind—oral, vaginal, or anal—with anyone. If they answer "no," then you can ask if they have ever had sex of any kind with another person. If they have had sex before, be sure to ask how many sex partners they have had in recent months. You can then ask what the genders are of their sex partners and whether they or their sex partners currently have other sex partners.

2. Practices

You can then move on to sexual practices. You can explain that you need to ask some more specific questions about the kinds of sex they have had over the last 12 months to better understand if they are at risk for STIs. Ask them if that is okay. If they are okay with continuing, you can tell them that there are different tests that are used for the different body parts people use to have sex. Ask them about the kinds of sexual contact they have or have had. Specifically ask what parts of their body are involved when they have sex. You can clarify by asking whether they have genital sex (penis in the vagina), anal sex (penis in the anus), and/or oral sex (mouth on penis, vagina, or anus). You can ask if they are a top and/or bottom. Also, during this time, you can ask whether they or any of their partners use drugs. And you can ask whether they have exchanged sex for their needs (money, housing, drugs, etc.).

3. Protection from STIs

The third "P" focuses on protection from STIs. You can ask your patient whether they



and their partner(s) discuss STI prevention. And you can talk about the types of prevention tools they use (i.e., external or internal condoms—also known as male or female condoms—dental dams, etc.) and how often they use these methods. If your patient needs more prompting, you can ask about how frequently they use prevention methods and in what situations or with whom. This is the time to ask whether they have received human papilloma virus (HPV), hepatitis A, and/or hepatitis B shots. And this is the perfect opportunity for discussing pre-exposure prophylaxis (PrEP) for HIV and educating your patient on its use and effectiveness.

4. Past History of STIs

Knowing your patient's history of past STIs will help you learn more about their familiarity with STIs as well as any risk factors for future STIs. So, you can begin the conversation by asking whether they have ever been tested for STIs and if they were diagnosed with an STI in the past. If they answer "yes," you can probe a little more about when they were diagnosed, if they had treatment, and if any of their symptoms keep coming back. You can ask them if they would like to be tested now. Additionally, inquire whether their current partner and any former partners were ever diagnosed or treated for an STI. As well, be sure to ask them if they know their partner's (or partners') HIV status.

5. Pregnancy Intention

The last "P" of the CDC's sexual history guide concerns pregnancy. This is the time to talk to your patients about whether they would like to have children—or more children—at some point. You can ask them when they would like to have children, and how important it is to them to prevent pregnancy until then. During the discussion, you can ask if your patient or their partner is using contraception or practicing any form of birth control. You can ask if they would like to talk about ways to prevent pregnancy or if they need any information on birth control.

The National Coalition for Sexual Health has introduced a new sixth P that addresses pleasure, problems, and pride. The sixth "P" builds upon the CDC's "five Ps" approach and explores sexual satisfaction, functioning, concerns, and support for one's gender identity and sexual orientation.

Conclusion

The importance of sexual health history taking cannot be overemphasized. While sexual health is an important part of one's overall health, health care providers do not routinely assess patients' sexual health. Providers need a socio-cognitive and sociocultural paradigm shift in terms of the prevalence and importance of sexual dysfunction in their adolescent and adult patients. One of the barriers seen in taking sexual history among providers is the belief that patients will be

uncomfortable if they attempt to discuss sexual health. However, it is the other way around. Patients are eager to discuss sexual health with their primary care providers; they are often uncomfortable, though, to initiate the conversation. Therefore, it is of importance that providers are trained on how to facilitate and discuss sexual health issues and concerns. As well, sexual health assessments should be added to health care system EHRs to help providers ensure that critical sexual health data is captured and can be accessed for future health care visits. **HIV**



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Transgender *and*
Gender-Diverse
Health Care *and*
Sexual Health

TRANSGENDER AND GENDER-DIVERSE (TGD) individuals, or those whose current gender identity varies from their sex assigned at birth, have specific needs regarding their general health, sexual health, and human immunodeficiency virus (HIV) management and prevention. TGD primary care includes the provision of gender affirming hormone therapy (GAHT), facilitating access to gender affirming surgeries (GAS), body-positive sexual health, and HIV treatment and prevention.¹ The most important part of working with TGD patients is respecting their identity. This includes documenting and using the correct name and pronouns, using an organ inventory to keep track of necessary screening measures, and using sensitive language during the physical exam and patient encounter.

The Basics of Respect

Assessing and using the correct pronouns with TGD people is an important first step when seeing new or established transgender patients. Asking about pronouns will signal to the patient that the clinician cares about offering culturally competent care.² Pronouns are just the first step in this conversation. Pronouns might include she/her/hers, he/him/his, they/them/theirs, or neopronouns such as ze/hir/hirs. Documenting pronouns in the chart in such a way that all staff can see the correct pronouns and use them is an important element of transgender cultural competency.

The same goes for the name the person is using, which may be different from their legal name or the name on their identity documents. The patient's legal and correct gender may also differ which can lead to problems with both identity documents and health insurance coverage for gendered procedures. It is important to work with clinical laboratories to make sure they are able to run gender discordant lab tests, such as cervical cytology and HPV typing for TGD people whose legal gender is male. All patients should have the right to decide what name should be used for themselves, and this should be considered the "correct name" for the patient and documented similarly to pronouns so all staff can see and use the correct name.

There are many ways people describe their gender, and many ways to experience being TGD. Discussing identity with patients is an important way to build trust and can form the basis of a relationship between patient and provider. Transfeminine spectrum patients, or those male assigned at birth and transitioning away from a male gender identity, may identify as transgender women, women of transgender experience, nonbinary, or as other identities they may describe to their clinician. Transmasculine spectrum patients, or those female assigned at birth transitioning away from a female gender identity, may identify as transgender men, men of transgender experience, nonbinary, or something else as well.

Nonbinary identities are highly varied and indicate that a patient identifies as neither a man nor a woman. Nonbinary people may use a variety of pronouns, including they/them/theirs, and have a variety

of experiences with their gender. From the clinician's perspective, it is important to know that nonbinary people may be seeking a variety of gender-affirming services and clinicians should let nonbinary people take the lead in planning what medical or surgical interventions will make their body and gender easier to live inside. See Table 1 for questions to assess someone's gender identity and pronouns.



Gender-Affirming Care

In the American medical system, a diagnosis is required in order for someone to access medical and surgical interventions. The ICD-10 and DSM-V describe "gender dysphoria" as a state of distress due to the mismatch between a person's sex assigned at birth and current gender identity.^{3,4} ICD-11 updates this diagnosis to "gender incongruence," meaning there is no requirement for distress in order to access care. ICD-11 also moves gender incongruence from being a sexual health disorder to a health condition, which destigmatizes the diagnosis and allows for people to access gender-affirming medical and surgical interventions without experiencing distress.⁵

The treatment for gender incongruence often, but not always, includes gender-affirming hormone therapy (GAHT) and gender-affirming surgery (GAS). Transfeminine spectrum patients may be seeking estrogen therapy with or without testosterone suppression and surgery to align their body with their feminine gender identity, such as facial feminization, breast augmentation, or vaginoplasty. Transmasculine spectrum patients may be seeking testosterone therapy, particularly menstrual suppression,

and surgery to align their body with their masculine identity, such as mastectomy (commonly called “top surgery”), body contouring, or genital surgery.

Health care professionals should be aware of alternative body-altering modalities used in TGD care, like free silicone injections. Free silicone is associated with major side effects, such as infections, silicone migration, granuloma, pneumonitis, pulmonary embolism, and major organ failure.* Silicone injections can also cause elevations in serum calcium, lactic dehydrogenase, and alkaline phosphatase.

Prior to initiating hormone therapy, it is important for clinicians to counsel patients on fertility preservation. While both testosterone and estrogen therapy interfere with fertility and make it more difficult to become pregnant or impregnate someone else, they are not reliable as birth control. Fertility counseling should include options for freezing sperm or eggs, and may not be covered by health insurance.

Working with TGD people also requires consideration of many psychosocial issues that uniquely affect this population. TGD people are more likely to experience violence, discrimination, and tobacco use as well as drug and alcohol use due to the stigma and discrimination they face every day.⁶ They often have a history of experiencing stigma, discrimination, and violence in the health care setting.⁶ Patient-centered and trauma-informed approaches to care will lead to better outcomes for this population than care that does not account for these psychosocial difficulties. Maintaining connections with TGD-friendly programs for tobacco cessation as well as programs for substance dependency is important to meeting the needs of the TGD population as well as seeking post-graduate education on TGD care.

Stigma and discrimination lead to depression and poor mental health outcomes as well. In one survey in 2015, 38 percent of TGD people nationally had attempted suicide.⁶ Health care providers working with TGD people should strive to help their patients cope with the stress of stigma and discrimination that drives these disparities and maintain referrals for behavioral health resources.⁷

* There are a variety of masculinizing genital surgeries to create a phallus using the clitoris, which is typically enlarged from testosterone therapy, or skin flaps from different sites based on patient and surgeon preference.



Sexual Health

There are many special considerations to maintain cultural competency while discussing sexual health. Table 1 provides prompts to use with patients to have these conversations. It is also important not to use anatomical terms for TGD people's bodies when they have not had GAS. TGD people may be uncomfortable with these terms and have different words they use to describe gendered body parts. Screening and sexual health guidelines for cisgender people can be used in the transgender population before GAS, and it is important to test all anatomical areas the TGD person uses for sex. Transmasculine people with a cervix report a strong preference for HPV self-swabs over speculum exams.⁸

Health care providers taking care of TGD patients should educate their TGD patients that sex can lead to pregnancy even when on GAHT. There is a risk of pregnancy whenever someone who ejaculates semen has insertive vaginal sex with someone who has a uterus and ovaries. If pregnancy does occur in a transmasculine individual on GAHT, they should immediately stop testosterone to prevent harm to the fetus. Counseling regarding contraception and emergency contraception (EC) should be provided with inclusive consideration to the sex assigned at birth of both partners and their current sex organs.⁹

Postoperatively, significant attention should be paid to the function and comfort of newly created sex organs as well as continued discussion of safety and screening for sexually transmitted infections (STIs). Complications to GAS can include postoperative pain, mental health challenges, poor sex organ function, and withdrawal from pain medications. One common vaginoplasty complication is stricture of the opening of the vagina.¹⁰ Surgeons often counsel patients that they do not need to continue dilating, or inserting a stent into the vagina for 20 minutes at a time to keep the introitus patent, beyond one year, or can dilate once a week after one year. Clinical experience suggests that dilation is a life-long practice and necessary to keep the introitus patent and will aid in receptive vaginal sex. Phalloplasty and metoidioplasty often have urethral complications, but it is also important to ask patients about sexual function as they may have difficulty with erectile implants or other problems with insertive sex.¹¹

These complications can hinder TGD patients reaching out for STI testing and HIV prevention and treatments. STIs can be transmitted after surgery through skin or mucosal tissue. Urine tests have not been validated in patients who have undergone vaginoplasty or phalloplasty, but may be adequate for phalloplasty. Standard penile inversion

Table 1: Important questions when working with TGD people

Question	Rationale
"I use (insert your pronouns). What pronouns do you use?"	Establishes rapport with TGD patients and sets a baseline for respectful interaction as well as eliciting necessary information.
"How would you describe your gender?"	TGD people identify in a variety of ways; allow them to define their gender in their own terms.
"Can we talk about your sex life?"	Rather than asking, "Are you sexually active?" which may miss some behaviors and creates a false binary of sexual activity.
"How do you like to have sex?" or "What do you do when you have sex?"	TGD individuals may engage in a wide range of sexual activity, including oral, anal, or genital sex. It is important to ask if people have insertive sex (or "top"), receptive sex (or "bottom"), or both insertive and receptive sex (or "versatile"); do not assume that someone only has a certain type of sex because of their identity.
"What are the gender or genders of your sexual partners?"	Allows for a discussion of any gender of partner and opens up the conversation to having multiple partners.
"How many partners do you have in an average week?"	This question is a less stigmatizing way to assess about multiple partners and is more focused on risk stratification than asking a larger period of time.
"How much of the time do you use condoms or other barriers with your partners?"	Asking in a way that acknowledges that patients may not use condoms opens the door to a conversation about frequency of use rather than a binary using/not using; includes more than sex with a penis involved.

vaginoplasty does not result in a vagina that emits secretions, though many surgeons are using mucosal tissue as well.¹² Writers recommend using vaginal swabs to screen for gonorrhea and chlamydia postoperatively due to the lack of validation in transgender patients.

Very little data are available addressing the sexual health of transmasculine people. Current studies regarding transmen sexual health are not generalizable as they examine small convenience samples and often find transmasculine people do not get relevant sexual health education.¹³

HIV Treatment and Prevention

Transgender women are far more likely to have HIV than cisgender women, with a global HIV burden of 14 percent.¹⁴ This disparity is largely due to syndemic factors affecting transgender women, including lack of education, medical mistrust, and high levels of stigma that lead to depression, distress, and finding validation through sex.¹⁵ As a result, treatment and prevention of HIV in TGD individuals requires special attention in creating effective treatment plans. Offering GAHT and GAS will help promote virologic suppression

in these populations.^{16,17} Social transition, meaning changing one's pronouns, appearance, name, or other non-medical factors, also provides validation for TGD people. It is also important to address coping with stigma and discrimination among TGD people.¹⁸ Therapy and counseling are effective methods of helping TGD people cope with these stressors.⁷

Community support groups and activism can also help manage the effects of stigma by connecting with other TGD people to share experiences and support one another, also improving conditions for the family members of TGD people.⁷ Effective activism to enhance legal protections including employment nondiscrimination laws, laws protecting gender-affirming care, and anti-bullying laws are all effective in protecting TGD people and may have a positive effect on their mental health.⁷

There is also significant evidence to suggest that TGD people are concerned about drug-drug interactions with hormone therapy and both HIV treatment and pre-exposure prophylaxis (PrEP).^{19,20} It is important to address these concerns when starting new medications with TGD people to assist with

medication adherence. Additionally, there is some debate as to how GAHT affects tenofovir disoproxil fumarate (TDF) concentrations in both blood and rectal tissues.²¹ While PrEP is still effective for HIV prevention in TGD populations when taken daily, 2-1-1 or intermittent PrEP use should not be advised for TGD people on GAHT. Testosterone and estrogen are both CYP450 3A4 substrates; induction or inhibition of the 3A4 pathway should be considered when interpreting hormone levels.

TGD Youth and Sexual Health

There are several specific considerations for sexual health among TGD youth. The 2017 Youth Risk Behavior Survey (YRBS) found transgender youth were far more likely than their cisgender peers to be sexually active, use drugs or alcohol before sex, not use barrier protection during sexual activities, and have been forced to have sex.²² This increased participation in high risk behaviors is paired with a lack of meaningful sexual education in school. High school sexual health curricula do not address the needs of TGD people; lack discussion of sexuality, gender identity, condom use; and often make sexual and gender minority youth feel alienated and scared during the sexual health education classes.²³ Sexual activity is often defined in sex education curricula as heterosexual penis-in-vagina sex without discussion of the types of sex relevant to TGD youth.²³ These factors of higher risk behavior and lack of meaningful education make the medical setting an important arena for TGD youth to get accurate information about navigating safer sex.

Sexual health programming for TGD youth should be tailored to the individuals receiving education.²³ For example, transmasculine individuals have different sexual health needs, such as pregnancy prevention, than transfeminine individuals who are engaged in commercial sex work.²⁴ Sexual health education for TGD youth should also consider the process of coming out, sexual violence, substance use, healthy relationships, and testing for STIs.²³ It is also worth noting that participation in commercial sex work among transfeminine youth may have some secondary benefit, with those participating in sex work experiencing a higher level of perceived social support than those who do not.²⁴

Few studies have been conducted focusing on young transgender people. Transgender women are often aggregated into studies of young men who have sex with men (YMSM) and no studies exist examining the health of young transmasculine people.²³ Some gray literature exists discussing transgender men, such as PUMP: Sexual and Pleasure Health Resource Guide for Transgender Men who Have Sex with Men, which offer resources for trans men on communicating about their bodies with partners, navigating safer sex, and types of sex that might be pleasurable.⁹ Including sexual pleasure in sexual health education is important for transgender people who may not have models for understanding sex, pleasure, and safety in sexual health education.

Transgender Bans and Health

Recent legislation against LGBTQ and TGD individuals have increased in the last three years. These laws create barriers to gender-affirming care, including gender-affirming sexual health care. Legislation that bans gender affirming care affects the mental and physical health of TGD people by increasing discrimination, creating fear of disclosing TGD identities, and prohibiting life-saving gender-affirming care. Physical health consequences include sleep disturbances, headaches, and gastrointestinal symptoms.²⁵ TGD youth of color are experiencing more challenges navigating their health care under these laws, leading to higher rates of violence, discrimination, and socioeconomic and mental health challenges.²⁵ Safehaven bills that protect gender affirmation within states and shield laws that protect medical providers in offering gender-affirming care across state lines promote the health of TGD people and should be pursued as a method of health promotion for this population.²⁶ **HIV**



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Sexual Health Education and Care for Youth with Disabilities

What Providers Should Know

By Shanon S. Taylor, EdD

AS HEALTH CARE PROVIDERS IN THE HIV FIELD, everyone reading this article understands the importance of quality sexual health education. Sexual health and sexual activity are part of the human experience, yet often we are reluctant to face the need for fact-based education on sexual health for our youth. This is especially true for our adolescents and youth with disabilities. It is critical that youth with disabilities receive high-quality sexual health education in order to be able to make informed choices regarding personal safety, maintaining sexual health and hygiene, and learning how to develop and maintain healthy intimate relationships.^{1,2} However, not all youth are receiving high-quality sexual health education and even fewer youth with disabilities receive such education, placing them at increased risks for sexual victimization, teen pregnancy, and acquisition of sexually transmitted infections (STIs), such as HIV.

The State of Sexual Health Education

Sexual health education can be classified in two ways: as abstinence-based or comprehensive-based. Abstinence-based sexual health education is exactly what it sounds like; it's a curriculum based on the concept that youth should abstain from sexual activity. The United States (U.S.) has long had a Puritanical view towards sexual behavior, which became woven into political, educational, and public health policy.³ This continued into the twentieth century and into some of the first federal funding initiatives for sexual health education in the early 1980s, such as the Adolescent Family Life Act, which counseled adolescents on the dangers of sexual activity outside of marriage and the benefits of adoption, rather than abortion, in the case of pregnancy.^{2,4} However, with research being conducted on human sexuality in universities in the 1950s and 60s and opening up more public discussion about sexuality, comprehensive sexual health education grew.⁵ A major step in this growth was the founding of the Sexuality Information and Education Council of the United States (SIECUS) in 1964. SIECUS created the National Coalition to Support Sexuality Education (NCSSE) and consistently tracks and reports on the status of sexual health education across the country.

Whether abstinence-based or comprehensive-based, there has long been a recognition that youth were engaging in sexual behaviors that resulted in STIs and early pregnancies. As early as 1892, the National Education Association discussed sexuality education



under the guise of “moral education.”⁶ By the 1920s, 40 percent of schools in the U.S. had provisions for social hygiene and sexuality education, and today every state has allocated funds for sexual health education.⁷ However, whether they provide comprehensive sexual health education or abstinence-based remains a continuous debate.⁸

There has been significant research to demonstrate that comprehensive-based

sexual health education increases the use of condoms and contraception, delays the initiation of sexual activity, and is associated with significantly lower rates of teen pregnancy than abstinence-based sex education, yet politics continue to mandate abstinence-based sex education.^{9,10,11} Congress began tying funding for sexual health education to requirements to provide abstinence-based programs, even as research demonstrated a lack of efficacy for these programs.⁶ At a time when educators were being told they must use evidence-based practices for academic instruction, Congress told them they had to use practices that weren't evidence-based for sexual health education in order to receive funds to then be able to use the evidence-based practice if their state or district chose to do so.

Sexual Health Education for Students with Disabilities

This is the state of sexual health education for the general education population. Students with disabilities often don't even receive this limited information. As sexual health education in the schools was expanding through the twentieth century, students with disabilities were often not receiving the same information as their peers without disabilities.^{12,13,14} Persons with disabilities were often viewed as "unfit" or "defective," and the earliest proponents of sexual health education and birth control were also proponents of eugenics and sterilization to prevent reproduction by those viewed as "unfit and feeble-minded."¹⁵

While we have made advances in how we educate students with disabilities, we still are lacking in services and resources when it comes to providing sexual health education for these students. There are a number of barriers that have been identified by researchers that currently contribute to this lack of effective sexual health education for this population. Some of the identified barriers include:

1. Sexuality of individuals with disabilities is viewed as deviant.^{16,17,18}

Despite the advances in inclusive education, overall views regarding the sexuality of individuals with disabilities have not changed much in the last 100+ years. Individuals are viewed as having uncontrollable libidos, or any instruction is geared to prevent abuse.¹⁸ There is no consideration that persons with disabilities may enter into sexual activity for enjoyment or as part of a mutual relationship.^{19,20} Finally, when education is provided, it is typically only from a heterosexual point of view; there is no consideration that individuals with disabilities may present as LGBTQ, and parents often report these sexual behaviors as "experimentation," while individuals with disabilities have reported confusion about being gay and not knowing where to go to find answers to questions about same-sex relationships.^{21,22}

2. Issues in teacher preparation, knowledge, and fear.^{23,24,25}

Teachers are generally unprepared to provide sexual health education and feel uncomfortable to teach it in general education settings.²⁴ This discomfort becomes heightened when teachers are asked about providing sexual health education to students with disabilities. Teachers

have identified being afraid that families want their children "protected" and often only provide sexual health education as an intervention after what is believed an inappropriate behavior has occurred.²⁶ These fears often lead to students with disabilities being excluded from sexual health education programs in schools.

3. Parental anxiety and fears.^{27,28}

Teachers' fears are often connected to parents' fears and anxiety. Parents have verbalized concerns that educating their children with disabilities about sexual health issues will cause them to engage in sexual activity. In some cases, the parents of children with disabilities view their child as asexual and not in need of sexual health education. Studies have also shown mixed results on what parents of youth with disabilities believe about the provision of sexual health education. In some cases, parents clearly feel unprepared to provide the proper information to their child with a disability, while in other cases they believe they should be the only individuals to provide sexual health education to their child.^{29,30}

What This Means for Individuals with Disabilities

All of these current barriers add up to a lack of effective sexual health education provision for individuals with disabilities. This lack of education and resulting lack of knowledge leads to dangers for our youth with disabilities. Youth with disabilities are approximately three times more likely to be sexually abused than their peers without disabilities.³¹ A review of research on individuals with disabilities and HIV found that, overall, individuals with disabilities were more likely to engage in high-risk behaviors, such as unsafe sex, transactional sex, and substance abuse.³² Additionally, the stigma surrounding disability and the social isolation may lead to vulnerability factors that put girls and women with disabilities at higher risk for sexual abuse and contracting HIV.^{23,33} Finally, youth with disabilities show lower self-efficacy than their peers without disabilities in negotiating safer sex practices with partners.^{34,35}



What Health Care Providers Should Know

As health care providers, you should know that when working with an individual with disabilities, they may not have received the same sexual health education your patients without disabilities have received, so they may have limited to no sexual health knowledge. It is important to remember that regardless of disability, all individuals are entitled to make decisions and choices about their own body, including their sexual health. When working with individuals with disabilities, the concept is called self-determination, the ability of a person to be responsible for their own life, and it includes components such as self-awareness, goal-setting, independence, risk-taking, safety skills, self-advocacy, and positive attributions of efficacy.³⁶ All of these components relate to being able to make health choices about one's sexual health.

Health care providers must not jump to the same assumptions about youth with disabilities that have created the barriers to them receiving appropriate sexual health education. Recent studies have demonstrated clear biases health care providers may hold regarding care for individuals with disabilities, specifically regarding sexual health care.³⁷ For example, doctors have reported not providing Pap smears, STI testing, or

discussing contraception options to women with disabilities due to incorrectly assuming they are not sexually active nor at risk of contracting an STI or becoming pregnant.³⁸

To meet the needs of your patients appropriately, you should understand their disability. Broadly speaking, you may work with patients who have physical disabilities or cognitive disabilities. Each come with different sets of needs. It is important to know that individuals with physical disabilities often report sexual dysfunction or pain with intercourse. This may be due to their physical disabilities or anxiety stemming from their disability.^{39,40} Also, it is important for you to look at the physical space in your office for accessibility. Can your doors allow a wheelchair to access? Do you have at least one examination table that can lower and have you and your staff been trained on the safe methods to lift and position patients who need physical assistance?

If your patient has a caregiver, you should also offer a private examination without the caregiver present, as your patient may not feel completely forthcoming discussing questions of sexual health in front of the caregiver. Most of all, you should demonstrate to your patient that not only are you knowledgeable in your field, but you also understand disability and you can answer questions about how

their disability might affect sexual health, and do so in an empathetic manner; this builds trust, which individuals with disabilities often report is lacking in their relationships with health care providers.⁴¹

If you are working with a patient with a cognitive disability, again, it is recommended you make time to examine the patient in private to allow them to speak to you about sexual health concerns without a caregiver present. Some individuals with an intellectual or other cognitive disability may have a legal guardian, but even while the guardian may consent to medical decisions, the individual still has the right to have private conversations with a health care provider.⁴² This privacy can be critical, as individuals with intellectual disabilities are more likely to experience abuse, sometimes from caregivers (especially if they have a paid caregiver). Because research has shown increased risk for STIs, women with intellectual disabilities should receive routine sexual health screenings. However, if the patient shows anxiety or confusion with a vaginal exam, testing that can be completed through urine or blood samples would be preferable.

There are a number of resources online that can be helpful for you as a health care provider. A wonderful place to start is "Our Sexuality, Our Health" (published by the University of California, San Francisco), an advocacy guide written by a woman with a disability that also provides directions for health care providers on how they can effectively work empathetically with their patients with various disabilities. If you want an in-depth background on the topic, the online journal *Impact* from the Institute on Community Integration published a special issue on disability and sexuality with articles on multiple topics from different viewpoints. A training for health care providers specifically about sexual health issues for women with disabilities is available from the Association of University Centers on Disabilities called "Reproductive Health Care for Women with Disabilities," which discusses specific issues health care providers should be aware of when caring for a patient with a disability.

Conclusion

Sexuality is a normal part of human life and all individuals, regardless of physical or cognitive ability, are entitled to sexual education and health care that allows them to lead productive lives. Adolescents and young adults with disabilities often are starting their sexual lives at a disadvantage, without the benefit of comprehensive sexual health education. As health care providers, it is critical you break down any previously constructed barriers, provide education where needed, answer your patients' questions and concerns, and provide sexual health care equitably, regardless of disability. **HIV**



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It's More Than Just a Blue Pill: Sexual Health, Aging, and Quality of Life

Implications for the Care Team

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Estimated time to complete: 30 minutes

TARGET AUDIENCE

This activity is intended for frontline providers of care to persons at risk for or who are living with HIV, including specialist and primary care Physicians, NPs, PAs, Nurses, and Pharmacists. Other HIV care team members are also encouraged to participate.

DESCRIPTION/LEARNING OBJECTIVES

The presentation on which this article is based was selected by ACTHIV® 2023 conference attendees and the conference planning committee as being among the best sessions of the conference. The goal of this article is to help members of the frontline HIV care team to be better able to:

- Describe the significance of sexual health as part of aging.
- Discuss strategies to address the sexual health needs of older adults in clinical practice.
- Identify challenges and opportunities for promoting prevention strategies among persons aging with HIV and those at-risk of acquiring HIV.

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It's More Than Just a Blue Pill: Sexual Health, Aging, and Quality of Life

Implications for the Care Team

BY JEFFREY KWONG, DNP, MPH, AGPCNP-BC, FAANP, FAAN, AAHIVS

MORE THAN 50 PERCENT OF PEOPLE WITH HIV (PWH) in the U.S. are 50 years or older, and that number is expected to increase as people age into older adulthood.¹ Addressing the needs of older PWH and those at risk for HIV are important considerations for the HIV care team. One aspect that is often overlooked or minimized when caring for older adults is the area of sexual health.

Sex and Quality of Life

The World Health Organization considers sexuality and sexual health a state of physical, emotional, and mental well-being that is central to being human and extends throughout one's lifetime.² This holistic perspective of sexual health is important for care team members to understand, especially in the context of aging. Clinicians must recognize that sexual health and sexual activity encompass more than just penetrative intercourse. Sexual expression for older adults can also include touching, kissing, and physical closeness. These forms of sexual expression provide a source of emotional connectedness, intimacy, and pleasure for older adults.

In 2022, the International Coalition of Older People with HIV issued "The Glasgow Manifesto," a proclamation of health priorities important for persons aging with HIV.³ One of the manifesto's top priorities was that sexual health be recognized as a vital part of overall health and quality of life. Although quality of life is important for everyone across the age continuum, it becomes even more salient for older adults. Several studies have found that older adults who report regular sexual activity experience improved quality of life and fewer health problems, including a decrease in age-associated cognitive changes.^{4,5}

How Much Sex are Older Adults Having?

According to the National Poll on Healthy Aging, 40 percent of persons 65 to 80 years old report being sexually active.⁶ Data from England found that 31 percent of men and 14 percent of women 80 years or older were sexually active, and in a Swedish study, 10 percent of those 90 years or older reported being sexually active.⁷ One study of sexually active 75- to 85-year-olds reported that 54 percent had sex at least two to three times per month, and 23 percent reported having sex one or more times per week.⁸



Factors Impacting Sex and Sexual Health

Many factors can affect sex for older adults. These can include physical or physiologic changes as well as social factors.

Physical. Physical or physiologic changes associated with decreases in androgens or complications from other chronic conditions may affect libido, erectile function, and vaginal lubrication.⁹ Medications, such as antidepressants or certain anti-hypertensives, can impact sexual function. However, it is important for HIV care team members to remember that there are other factors that may be less obvious. For instance, arthritic changes may affect sexual positioning or may limit the ability to engage in sexual activity due to pain. Comfort with one's body can impact the desire to be sexual. Older adults may experience changes in weight, loss of skin elasticity, a decrease in muscle mass, or have surgical procedures (such as mastectomies, prostatectomies, or stomas that result from treatment for malignancies). All these factors may deter some from wanting to have sex with others.

Social. Social factors play a role as well. Individuals may experience changes in their relationship status (e.g., going from being partnered to being widowed or divorced). Opportunities to meet new sex partners may be limited because of changes in living situation (e.g., people transition from independent living to an assisted living). One may experience changes in access to transportation (e.g., the ability to drive or use public transportation may be limited because of physical abilities), thus limiting the ability to socialize and meet new people.

Let's Talk About Sex

Although discussion of sexual health may seem straightforward, there are cultural, societal, and system-level issues that can impede these critical discussions during medical visits, thus creating barriers for patients. Older adults may be less inclined to bring up the topic of sexual health due to embarrassment or fear of being judged. They may not feel empowered to bring up a topic with a health care professional or believe that only topics initiated by the clinician are appropriate to discuss during a visit.¹⁰ From a system-level perspective, care team members may lack appropriate training in taking a sexual history from an older patient or may be working under time constraints that limit the ability to have an in-depth conversation about sexual health.¹¹ Finally, ageism and misconceptions about older adults is another factor that can influence discussions about sexual health.

In terms of clinician education, data suggest that more than half of medical, nursing, nurse practitioner, and physician assistant curriculums contain less than 10 hours on sexual health; 44 percent of U.S. medical schools lack a formal sexual health course; and one out of six nursing instructors thought their students were capable of managing sexuality concerns.¹² Similar gaps exist in pharmacists' education, with some programs devoting only four to eight hours of curriculum content on sexual, reproductive, or LGBTQ health topics.^{13,14} The fact that many care team members may not have the skills or the confidence to discuss the sexual health needs of older adults creates a barrier to care. Unfortunately, although patients may wish to discuss sexual health with a provider, many individuals do not have these critical conversations. One study found that only 17 percent of 65- to 80-year-olds reported that they spoke with a provider about sex during their most recent medical visit. However, 60 percent of those individuals had to initiate the conversation themselves.¹⁵

Ageism: A Barrier to Prevention and Diagnosis

Ageism has been defined as stereotypes, prejudice, and discrimination related to old age, the aging process, and older adults, which can have a negative effect on the well-being of older adults.¹⁶ Ageism may be unintentional and can come from policies or practices that are inherent in the health care system. For instance, although HIV pre-exposure prophylaxis (PrEP) is recommended for persons at risk for HIV regardless of age, many public health campaigns or educational materials lack older adults in their visual ads or educational materials. This may unintentionally give the impression to both older adults and their health care professionals that HIV PrEP is not meant for older adults.

Similarly, current HIV screening guidelines have upper age limits for routine testing. The Centers for Disease Control and Prevention (CDC) recommends routine opt-out HIV testing for those 13 to 64 years old while the U.S. Preventive Services Task Force (USPSTF) recommends routine testing for those 15 to 65 years old.^{17,18} Ongoing testing for those over 65 is recommended for those "at risk." This upper age limit may lead care team members to be less inclined to order routine testing or to inquire about HIV risk in persons over 64. The state of New York removed the upper age limit from its HIV testing recommendations in 2017. New York's testing law states that HIV testing should be offered to those 13 years of age and older.¹⁹ This minimizes the potential for arbitrarily limiting testing to individuals over 65. Additionally, the assumption of the USPSTF guidelines is that clinicians can accurately assess if someone has risk factors for HIV. This would mean that a clinician would need to conduct an appropriate sexual and substance use risk assessment in older adults. However, as previously stated, data supports that this is not happening.

STIs, PrEP, and Older Adults

According to the CDC, rates of sexually transmitted infections (STIs) have increased significantly among those 65 and older. Between 2013 and 2020, cases of primary and secondary syphilis increased four-fold, chlamydia doubled, and rates of gonorrhea increased 3.5 times.²⁰ With regards to new HIV diagnoses, in 2019 nearly 11 percent of new HIV diagnoses occurred in persons over 55. Of note, between 2015 and 2019, there was a 15 percent increase in HIV incidence among those over age 55, representing the largest increase among any age group.²¹ Data have also demonstrated that when older adults are diagnosed with HIV, they typically are diagnosed with more advanced disease, suggesting that this population is not being screened for HIV on a routine basis.²²

Although HIV PrEP is available, use among older adults who could benefit from PrEP remains low. Data indicate that 21 percent of PrEP prescriptions in the U.S. were written for persons 55 years or older.²³ Of the currently approved PrEP options, there is no

It's More Than Just a Blue Pill: Sexual Health, Aging, and Quality of Life

ASSESSMENT QUESTIONS

1. TJ is a 72-year old cisgender male who presents with dysuria and a mucopurulent urethral discharge for three days. He is afebrile, denies any rash or flu-like illness. He reports having a new sexual encounter with another person 10 days earlier. He only takes sildenafil for erectile dysfunction. Based on the information provided, what would be important to include in his treatment plan for today?
 - A. Refer him to urology
 - B. Recommend stopping sildenafil
 - C. Empirically start treatment for prostatitis
 - D. Recommend HIV testing and inform him about HIV pre-exposure prophylaxis
2. The six P framework for sexual history taking includes asking about which of the following?
 - A. Pleasure
 - B. Panic disorder
 - C. Perimenopause
 - D. Post-exposure prophylaxis
3. Older adults who engage in sexual activity have:
 - A. Improved cognition
 - B. Fewer hospitalizations
 - C. Greater risk for heart disease
 - D. Increased odds of hip fracture

one option that is ideal for older adults. For example, oral tenofovir disoproxil fumarate (TDF)/emtricitabine (FTC) may not be ideal for persons with pre-existing renal impairment, and tenofovir alafenamide (TAF)/FTC and injectable cabotegravir can impact lipids and may not be ideal for persons with significant cardiovascular disease. The decision on which PrEP option to use should consider the type and frequency of risk, other co-occurring conditions, drug-drug interactions, as well as cost and insurance coverage.

Cost and Insurance Coverage

Cost of medications and coverage for associated laboratory testing can be a barrier for older adults who may be on a fixed or limited income. Generic formulations of TDF/FTC are available and provide a lower cost option for individuals. In July 2023, the Centers for Medicare and Medicaid Services (CMS) issued preliminary request for coverage of PrEP (both oral and injectable forms),

risk reduction counseling, as well as HIV testing up to seven times per year.²⁴ At the time of this writing, the CMS recommendation is open for public comment, and the final decision is anticipated before the end of 2023. Assuming that official approval will be forthcoming, this decision by CMS would provide improved access to HIV prevention services for Medicare beneficiaries. Of note, one of the key components of the CMS proposal is that “determination of whether an individual is at high risk for HIV infection is made by the physician or health care practitioner who assesses the individual’s history.”²⁴ Once again, this reinforces the need for clinicians to take an active role in eliciting a risk history and to have conversations about sex and substance use.

Strategies for Improving Sexual Health Discussions with Older Adults

One of the best ways to address the sexual health needs of older adults is to normalize

the discussion of sex and sexual health as part of routine care. This means care team members should ask or inquire about sexual health at every visit, or at least annually, regardless of perceived risk. During these assessments, clinicians should ask not only about sexual function, but also about pleasure, relationships, and any barriers or challenges to engaging in sexual activities. For individuals who report sexual activities with others, discussion about STI risk and STI prevention should be included. Even for individuals who may have had long-standing clinical relationships with a health care professional, it is important to not anticipate their responses to questions about sexual health and to keep the door of opportunity open for discussion.

There are several different frameworks that can help members of the care team conduct a sexual health history, including the CDC’s five P approach. Clinicians should ask patients about 1) partners, 2) practices, 3) protection from STIs, 4) past history of STIs, and 5) pregnancy intention.²⁵ More recently the National Coalition for Sexual Health introduced an additional “P” to the framework. The sixth “P” is for “plus,” and includes asking about or exploring issues such as trauma, violence, pleasure, sexual wellness, support for sexual orientation and gender identity, sexual concerns, or sexual distress.²⁶

One of the key points to remember is that discussions about sexual health can be difficult for both patients and clinicians. Establishing a good rapport with your patient and building a sense of trust and connection can help to solidify these discussions. Other points to keep in mind include using gender neutral language (using the term “partner”), avoiding medical jargon, being aware of eye contact, body language, and avoiding facial expressions that may be interpreted negatively. Additionally, it is critical to remember that assessment and management of sexual health is ideally suited for an interprofessional team. Initiating discussions and ongoing assessment can be done by all members of the care team (MDs, DOs, NPs, PAs, RNs, pharmacists, social workers, therapists, case managers, physical therapists, dental professionals). Regardless of which discipline initiates the discussion, the most important

thing is to make sure that the patient's needs are being met and their concerns addressed.

In conclusion, addressing the sexual health needs of older adults is a critical aspect of providing comprehensive, patient-centered care. Recognizing the connection between sex and quality of life for older adults can enhance patient-provider relationships, leading to improved communication, engagement, and retention in care. By opening the door to discussions about sexual health, opportunities exist for the care team to educate and inform older adults about the aging process, risk reduction, as well as HIV prevention strategies. **HIV**



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The HIV Clinical Leadership Fellowship Program

Q&A WITH A RECENT GRADUATE

BY SHANNA LIVERMORE, MPH, MCHES, FRSPH, MHFA,
and EARL CARLOS, MD

About the HIV Clinical Leadership Fellowship Program

The Los Angeles Area Pacific AIDS Education and Training Center at the University of Southern California (USC) created one of the first HIV Fellowships open to primary care physicians in 2001. Now in partnership with the Los Angeles County Department of Health Services (DHS), the second-largest municipal safety net system in the United States, the program offers a unique HIV fellowship for physicians committed to improving primary care for people with HIV in underserved communities. This program brings together the unique strengths of DHS, USC Keck School of Medicine's Los Angeles Area Pacific AIDS Education Training Center, the University of California Los Angeles National Clinician Scholars Program, and ViiV Healthcare.

The purpose of the fellowship is to train physicians in the knowledge and skills necessary to provide expert HIV care, to be health systems leaders, and to be successful community partners in patient-centered and community-specific HIV interventions.

A Recent Graduate's Experience

The director of operations for the HIV Clinical Leadership Fellowship Program, Shanna Livermore, MPH, MCHES, FRSPH, MHFA, recently talked with a new graduate of the program, Dr. Earl Carlos. Below is their exchange.

1. Why did you choose to pursue a career in HIV primary care?

My interest in HIV medicine started during my second year of family medicine residency training. I completed a two-month tropical medicine rotation in eastern Kenya in a town called Mutomo, about six hours from the capital, Nairobi. Being in a developing country that lacked essential resources to screen and educate all of its community, I was able to see the virus at its worst: PWH arriving to the hospital with AIDS-defining illnesses. Besides garnering my interest in tropical medicine, my curiosity about HIV began and I wanted to learn more to see if I could help be a part in improving HIV care to those who need it most.

2. What brought you to the HIV Clinical Leadership Fellowship Program in particular?

After residency in 2019, my very first job was with Doctors Without



Borders in Bentiu, South Sudan. I completed this six-month project and found myself wanting to not only become a better HIV clinician, but also to acquire skills to be a better leader and community developer. The HIV Clinical Leadership Fellowship was perfect in that sense. There were other HIV in primary care fellowships available, but I felt that this program embodied what I wanted to accomplish.

3. What did you particularly enjoy about the HIV Clinical Leadership Fellowship Program?

The fellowship really gets you accustomed to the different clinical settings where you may see PWH. Besides working in our outpatient infectious disease clinic (Rand Schrader Clinic), we were rounding with the ID service, picking up phone calls for consults at 1:00 a.m. at the emergency department, riding with the USC Street Medicine team in the mornings, while discussing medication assisted therapy to a patient in LA County's Men's Central Jail in the afternoon. This, by far, is the highlight of the program.

4. What was your favorite clinical experience and why?

This is such a difficult question, but I will have to say that rounding with the USC Street Medicine team was my favorite clinical experience. There were so many good people that I met in the program, both patients and clinical staff. They all do such great work that is often difficult to appreciate and, sometimes,



difficult to see progress in. We all know that everyone should have a right to a home with a warm bed and food to eat, but if this basic need is not met, taking medication for something like HIV gets that much more difficult. I enjoyed this rotation, because I also saw the flaws of my work as a doctor telling someone struggling with homelessness to take medications when there were so many other obstacles they were facing that day.

Plus, another reason was that I enjoyed the rides around the city. It was such a pleasure to see all of Los Angeles, both the good and the truth.

5. What was the best part of your training in the HIV Clinical Leadership Fellowship Program?

The best part of my training were all the lovely, wonderful mentors that I met along the way. I've always struggled to find good mentors, but I felt that I was bombarded in this program by so many good people who earnestly wanted to do good with their lives with the skills they have been given. Not only were the people that taught me in this program intelligent, but they were all so warm and friendly. The instructors of this program are the best and I miss them all so much!

6. How did the HIV Clinical Leadership Fellowship Program prepare you for a career as an HIV Specialist?

I felt that this program helped me out in two ways. First, it gave me the clinical skills

I needed to not only become a better HIV Clinician, but also to become an overall better doctor as well. Along with HIV knowledge, one who works with PWH has to be familiar with addiction, depression and anxiety counseling, infectious disease, and so much more. I have become a better generalist because of this program in that sense.

Secondly, this program also gave me the confidence to be out there in the community and be present wherever help is needed as a leader. During my second year of the program, I worked with a local federally-qualified health center to start an HIV prevention program with the goal of providing PrEP and other STI prevention strategies.

7. Now that you have completed the HIV Clinical Leadership Fellowship Program, where have you taken your career?

Currently, right now I am in the middle of a "self-sabbatical." I have taken some time off to evaluate what is it that I really want from my career in medicine (and to spend time with my one-year-old). Starting in September 2023, I have made myself available to go back out on my second mission with Doctors Without Borders. I currently do not have a placement yet, but likely it will be back in Sub-Saharan Africa doing HIV care. **HIV**



EARL CARLOS, MD, was born in Manila, Philippines, and moved to the United States when he was five years old. Before medical school, he worked in an AmeriCorps program in Chicago as a Community Resource Educator at Saint Anthony Hospital. He attended medical school at Nova Southeastern University and was a family medicine resident at Detroit Wayne County Health Authority (Authority Health) through Michigan State University College of Osteopathic Medicine. It was through residency that he was able to complete a tropical medicine rotation in Mutomo, Kenya. After residency, she served as an HIV and Tuberculosis medical doctor in a United Nations Protection of Civilians Camp in South Sudan through Doctors Without Borders. He hopes to play a part in helping close the gap in HIV care not only here in the United States, but globally as well.

INTERESTED IN BECOMING A FELLOW?

Candidates are competitively selected through a national search for this two-year fellowship program. Those selected will participate in the HIV Clinical Leadership Fellowship Program with a full fellowship salary and benefits. Up to four fellows may be selected for each cohort. Following satisfactory completion of the program, fellows with eligible academic loans may receive up to \$150,000 in loan repayment if they continue to provide HIV-related services in underserved communities.

Due to the geographic nature of the HIV epidemic, we highly encourage physicians with an interest in practicing in the South and Mid-Atlantic states to apply. Desired qualifications for potential candidates include:

- A strong interest in primary care and HIV medicine
- A strong interest in pursuing and implementing outpatient quality improvement or system innovation
- A sincere desire to work with underserved communities.

The HIV Clinical Leadership Fellowship Program is seeking applicants who are Board eligible, or Board certified in Family Medicine, Internal Medicine, or Medicine-Pediatrics. Applicants must have completed an accredited United States medical residency program. Please note the fellowship does not support international visas.

The application cycle for the 2023–2025 cohort is open through November 1, 2023.

Applications are accepted starting July 1 of each year at <https://www.hivfellowship.com/>



CAROLYN CHU, MD, MSC, AAHIVS

AAHIVM Chief Medical Officer

FEATURED LITERATURE:

Johnson KA, Burghardt NO, Snyder RE, et. al. Comparing 7 vs. 6-8 day penicillin treatment intervals among pregnant people with syphilis of late or unknown duration: no difference found in incidence of congenital syphilis. *Open Forum Inf Dis*. 2023 Jun 8. Online ahead of print. <https://doi.org/10.1093/ofid/ofad300>

This analysis of California STI surveillance data aimed to determine whether infants born to birthing parents with syphilis of late/unknown duration treated with three weekly doses of benzathine penicillin G (BPGx3) administered at six-to-eight day intervals (initiated ≥ 30 days before delivery) would be more likely to meet congenital syphilis (CS) criteria than infants born to parents who received BPGx3 at strict seven-day intervals. CS cases were defined using a combination of surveillance and clinical criteria. Between January 2016 and June 2019, 1,092 parent-infant dyads were eligible for analysis. A total of 607 parents (55.6%) received BPGx3 at strict seven-day intervals, 70 (6.4%) received treatment at six-to-eight day intervals, and 415 (38%) received no or inadequate treatment. There were no significant differences between parents receiving seven vs. six-to-eight day interval BPGx3 with regard to age, race/ethnicity, HIV status, receipt of prenatal care, trimester for establishing prenatal care, and highest non-treponemal titers in pregnancy. Parents who received no/inadequate treatment were less likely to have received prenatal care and were diagnosed with syphilis later in pregnancy, and almost 60 percent had not received any treatment prior to delivery. CS incidence proportions in the seven, six-to-eight day, and no/inadequate treatment groups were 5.6 percent, 5.7 percent, and 36.9 percent respectively. There was no difference in CS incidence between the first two groups.

AUTHOR'S COMMENTARY:

Despite a relatively small population involved in this retrospective analysis, these results suggest that six-to-eight day intervals of benzathine penicillin G for prenatal treatment of syphilis of late/unknown duration may potentially be sufficient. As authors note, having a small window of flexibility for indicating whether an intervention provides adequate CS prevention may translate into very meaningful impact in clinical and public health practice. More studies, including larger sample sizes and detailed case information, would help potentially replicate and/or expand upon this study's findings.

Disclaimer: Although employed at the same institution as the study's lead author, Dr. Chu was not involved in this research.

FEATURED LITERATURE:

Ogbuagu O, Segal-Maurer S, Ratanasuwan W, et. al. Efficacy and safety of the novel capsid inhibitor lenacapavir to treat multidrug-resistant HIV: week 52 results of a phase 2/3 trial. *Lancet HIV*. 2023 Jul 11; S2353-3018(23)00113-3. doi: 10.1016/S2353-3018(23)00113-3. PMID: 37451297

This analysis describes week 52 virologic outcomes of lenacapavir use in 72 highly treatment experienced participants with multi-drug resistance who were enrolled in a phase 2/3 multi-national trial. There were 36 individuals enrolled into cohort 1 and randomized to oral lenacapavir or placebo. At day 15, individuals were switched to optimized background therapy (OBT) plus lenacapavir. Cohort 2 included 36 participants who received OBT plus lenacapavir beginning at enrollment. Overall, 33/72 (46%) had investigator-reported resistance to at least two drugs in all four major ART classes and 12/72 (17%) had no fully active ARVs in the OBR. In cohort 1, 34/36 completed the main phase of 52 weeks, and 32/36 from cohort 2 completed the main phase of 52 weeks. At week 52, 30/36 (83%) in cohort 1 and 26/36 (72%) in cohort 2 had VL < 50 copies/mL (combined rate: 78%).

Efficacy was generally similar regardless of number of fully active ARVs in the OBR as well as use of dolutegravir, boosted darunavir, ibalizumab, or fostemsavir. There were 11 participants in cohort 1 and 11 in cohort 2 who met the criteria for resistance analysis: nine participants had capsid RAMs (eight with resistance up to week 26 and one with emergent resistance at week 52). All nine were at high risk of emergent lenacapavir resistance, with four having no fully active drugs in their OBR and five with inadequate OBR adherence. Despite emergent capsid RAMs, 4/9 resuppressed while maintaining lenacapavir use (two with and two without OBR change). No emergent INSTI or PI mutations were observed. Forty-seven out of 72 (65%) had at least one study drug-related injection site reaction. Median duration of injection site reactions after first injection was six days; median duration of nodules was 227 days and of indurations was 113 days. Lab abnormalities of grade three or higher occurred in 23/72 (32%) participants.

AUTHOR'S COMMENTARY:

Week 52 results for lenacapavir efficacy and safety are consistent with those previously reported for week 26, with one participant developing capsid resistance associated mutations after week 26. Injection site reactions were relatively common, and the duration of these reactions is notable. Given the trial's small sample size and potential challenges of both identifying and supporting ongoing adherence to an optimized background regimen, additional data and experience will be invaluable. Further, additional guidance on when to consider capsid resistance testing is needed.

FEATURED LITERATURE:

Inciarte A, Ugarte A, Martínez-Rebollar M, et. al for the DORAVIPEP Study Group. Doravirine/lamivudine/tenofovir disoproxil fumarate for nonoccupational HIV-1 postexposure prophylaxis: a prospective open-label trial (DORAVIPEP). *Open Forum Infect Dis*. 2023 Jul 19; 10(8):ofad374. doi: 10.1093/ofid/ofad374. PMID: 37539061

DORAVIPEP evaluated the use of co-formulated DOR/3TC/TDF as non-occupational post-exposure prophylaxis (PEP). This was a single-center, open-label, single-arm trial which included 399 non-pregnant adults (91% male and 84% MSM) seeking emergency department care after consensual, potential exposure to HIV between September 2019 and March 2022. Participants received a complete 28-day prescription, with the first dose initiated immediately on day zero. Of the participants, 34.6 percent reported prior PEP use and six percent had initiated pre-exposure prophylaxis (PrEP) prior to the study. During the follow-up period, 29 percent discontinued PEP early; median time reported for PEP duration was eight days. The most common reason for non-completion was loss to follow-up, followed by intolerance and adverse events. In multivariable analysis, PEP non-completion was associated with younger age; among individuals who attended at least one post-enrollment visit, both younger age and any AE emergence was associated with PEP non-completion. The most common AE types were gastrointestinal (35%), neurological (21%), and musculoskeletal (9%). No clinically significant laboratory value changes were observed, and laboratory abnormalities were not the reason for PEP non-completion in any participant. Self-reported adherence in assessed participants was 336/350 (96%) and 281/285 (99%) at day seven and week four, respectively. No cases of seroconversion were identified.

AUTHOR'S COMMENTARY:

Results of this single-arm trial suggest that co-formulated DOR/3TC/TDF is a very reasonable option for use as non-occupational post-exposure prophylaxis (PEP). Although the study didn't include a direct comparison with standard, INSTI-inclusive regimens, no significant safety concerns emerged. Overall, the tolerability of (and adherence to) DOR/3TC/TDF observed among this study's population are fairly similar to results from other contemporary PEP studies. Additionally, this trial's results highlight opportunities to revisit and refine laboratory (e.g., chemistry panel and hematologic) monitoring recommendations/practices as well as substance use/harm reduction and PrEP counseling integration into PEP programming.

FEATURED LITERATURE:

Shelton BA, Becker DJ, MacLennan PA, et al. Racial disparities in access to the kidney transplant waitlist among people with Human Immunodeficiency Virus. *AIDS Patient Care STDs*. 2023 Aug; 37(8):394-402. doi: 10.1089/apc.2023.0037. PMID: 37566535

Investigators sought to examine kidney transplant waitlist addition rates among adults with HIV, and also whether existing racial disparities in access to transplant waitlist persisted in the presence of an HIV diagnosis. Information related to demographic and clinical characteristics was retrieved from the U.S. Renal Data System, a national database of people with end-stage kidney disease which includes Medicare claims information. Patients with end-stage kidney disease entered the study (595,756 without HIV and 6,250 with HIV) and began contributing time-at-risk on the date of dialysis initiation, and were followed until the earliest of waitlist addition, death, living donor transplant before waitlist addition, or study conclusion on December 31, 2018. People with HIV (PWH) were significantly younger, Black (70% vs. 26.7%), and less commonly female (31.7% vs. 43.4%). Rates of reported alcohol and drug dependence were higher among PWH (3.0% vs. 1.4%). After adjustment for demographic and clinical features as well as geography, HIV status and race were independently associated with a 50 percent and 12 percent lower likelihood of waitlist addition, respectively. Investigators also observed a significant interaction between HIV status and Black race, with hazard ratios revealing that Black PWH had lower predicted likelihood of waitlist addition than White patients with ESKD, White PWH, and Black patients with ESKD.

AUTHOR'S COMMENTARY:

This national study is one of the first to specifically assess whether race and HIV intersect with regard to kidney transplant waitlist practices, and findings suggest that Black race and HIV status combined are associated with lower likelihood of waitlist addition than either Black race or HIV status independently. Given the disproportionate prevalence of HIV and kidney disease among Black populations, these findings highlight important opportunities for advocacy, collaboration, and information sharing for both provider and patient communities. **HIV**

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