

Chapter 11

Sexual Health





Sexual Health

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality (1). Achieving this state of well-being includes the prevention of, and when necessary, effective treatment of sexually transmitted infections (STIs), sometimes called sexually transmitted diseases (STDs) (2). The Centers for Disease Control and Prevention (CDC) estimates that 20 million sexually transmitted infections occur each year, with half of new diagnoses occurring in adolescents ages 15-24 (3). In 2015, combined cases of chlamydia, gonorrhea and syphilis reached the highest number ever reported (3). It was also the second year in a row in which increases were seen in all three of these reported STIs (3). The overall increase among these three STIs is due to increasing rates among men, however, young people and women are still those most affected by STIs (3). Overall, chlamydia, gonorrhea and syphilis are the three most commonly reported medical conditions in the United States (3).

Nationally there are higher rates of STIs among Black individuals. These elevated rates have been attributed to the impact of social determinants of health (4-7). Researchers at the CDC have proposed a socioecological model to describe racism, social determinants of health, and their impact on Black women's sexual and reproductive health (6). The authors describe how racism impacts social determinants of health, which in turn, affect individual behaviors and interpersonal relationships. In addition, sexually active people who live in communities with higher rates of infection may be more likely to get an STI than those who live in communities with low STI rates, even if they have the same behaviors (condom use, number of partners), because those in communities with high STI rates have a higher chance of selecting a partner who is infected (4, 8).

Symptoms and health effects

Many people are unaware they are infected with an STI. STI symptoms are often absent, or when present, may be attributed to another cause (9). Symptoms as benign as non-specific abdominal pain or itching can be the first signs of an infection with the potential to cause serious long-term complications if not treated (9). Uncontrolled infections can make an individual more vulnerable to other STIs, including HIV (10).

Although anyone can experience serious health effects from STIs, they impact women more frequently and extensively than men (11). Infections can cause pelvic inflammatory disease, infertility, and ectopic pregnancy if left untreated. It is estimated that undiagnosed STIs cause infertility in more than 20,000 women per year (11). Infections may also be passed on to an unborn child, causing serious harm including brain damage, blindness, or stillbirth (12). Often times, women do not have noticeable symptoms when infected with the most common STIs, and thus may not seek medical attention, whereas symptoms for men are more obvious (11).

Prevention strategies and treatment

Reducing the risk of becoming infected with an STI is the goal of recommended prevention strategies. Using condoms can prevent infection. Having honest conversations with new partners about infection and being aware of common STI symptoms can prevent STIs from spreading (13). Abstaining from sexual activity or being active in a long-term, monogamous relationship with an uninfected partner can prevent infection. High-risk behaviors for contracting an STI include having multiple partners, unprotected intercourse with infected persons, and injection drug use (2).

After prevention, seeking medical care immediately after a potential infection is the next best approach. Although many STIs do not present with obvious symptoms, they can be detected through targeted medical screening tests. Since bacteria are often responsible for infections, most STIs can be effectively treated with antibiotics. Even STIs caused by viruses, such as herpes and HIV, can be medically managed (2).

This section of the report presents data on chlamydia, gonorrhea, and HIV/AIDS.

Chlamydia

Chlamydia is by far the most frequently reported STI in the U.S., and is caused by the bacterium *Chlamydia trachomatis*. Nationally, over 1.5 million cases of chlamydia were reported in 2015, a 6% increase from the year before (3). While women were twice as likely to be infected with chlamydia, there were increased rates among men – 20% more men had chlamydia in 2015 than in 2011 (3).

Symptoms and health effects

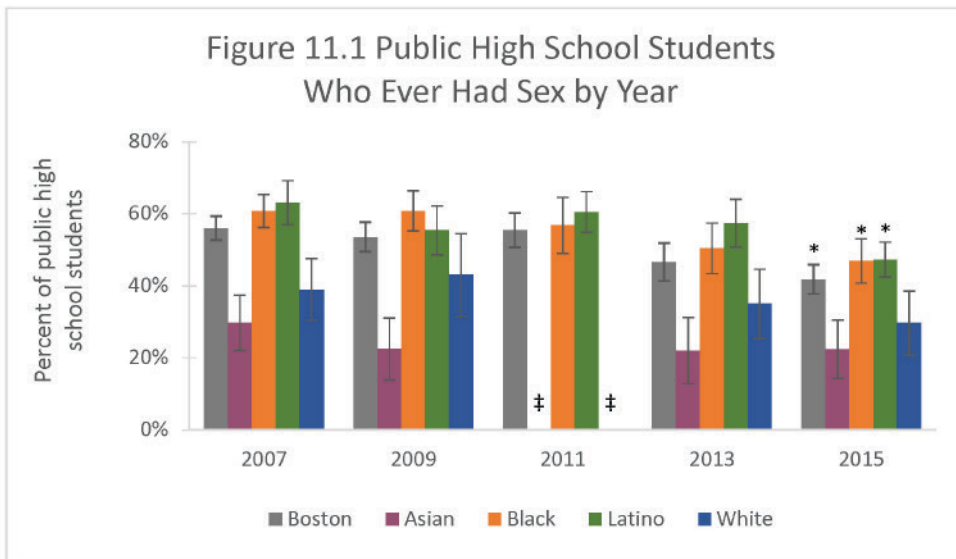
Chlamydia is considered a “silent infection” – most people are asymptomatic. If they do have symptoms, it is usually in the form of vaginal discharge for women and burning during urination for both men and women. While the symptoms are relatively minor, untreated infections can lead to serious consequences including pelvic inflammatory disease, infertility, and pregnancy complications. Infection can also be spread from an untreated mother to her baby during childbirth, which can cause conjunctivitis or pneumonia in the infant (14).

Screening, treatment and prevention strategies

Sexually active young people are at higher risk of acquiring chlamydia for several reasons related to behavior and biology. Nevertheless, any sexually active person can become infected. CDC recommends yearly chlamydia screening of all sexually active women ages 25 and younger, and older women with new or multiple sex partners (2). Due to the disease’s asymptomatic nature, a laboratory test is usually necessary (2).

Chlamydia infections can effectively be treated with antibiotics, which stop the infection, but sometimes the damage caused by the infection is irreversible. Therefore, treatment is most effective when delivered as soon as possible after exposure. Repeated infection is common and can occur if a person’s sex partners have not been treated (14). Chlamydia infection can be prevented by using barrier contraception. In Massachusetts, partners of patients with chlamydia can be treated without needing to be tested to prevent spread of the disease.

Figure 11.1 Public High School Students Who Ever Had Sex by Year



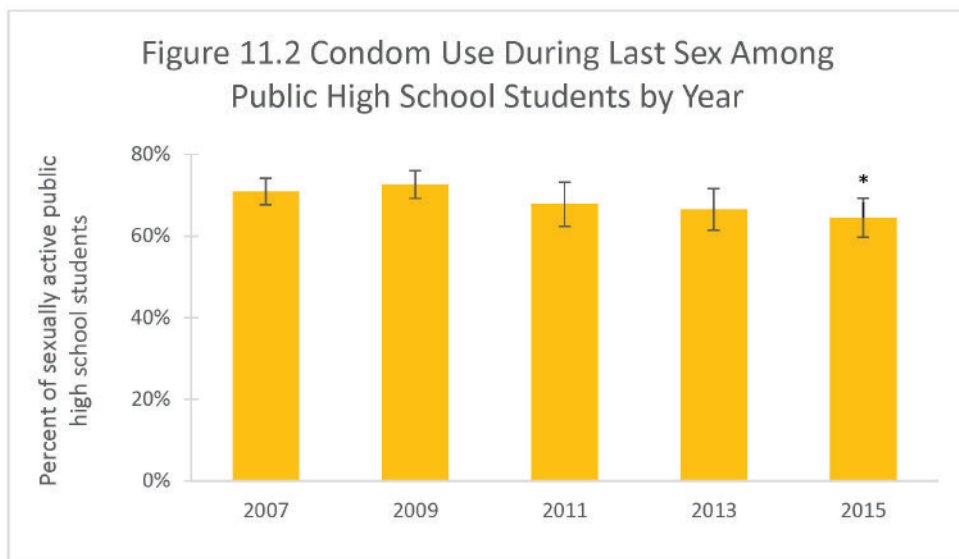
* Statistically significant change over time for the indicated groups
 † Data not presented due to insufficient sample size

DATA SOURCE: Youth Risk Behavior Survey (2007, 2009, 2011, 2013, 2015), Centers for Disease Control and Prevention and Boston Public Schools

In 2015, 42% of Boston public high school students had ever had sex. Between 2007 and 2015, the percentage of students who had ever had sex decreased. The percentage of Black and Latino students who had ever had sex also decreased from 2007 to 2015.

In 2015, the percentage of Black (47%) and Latino (47%) students who had ever had sex was higher than the percentage of White students (30%) who had ever had sex.

Figure 11.2 Condom Use During Last Sex Among Public High School Students by Year

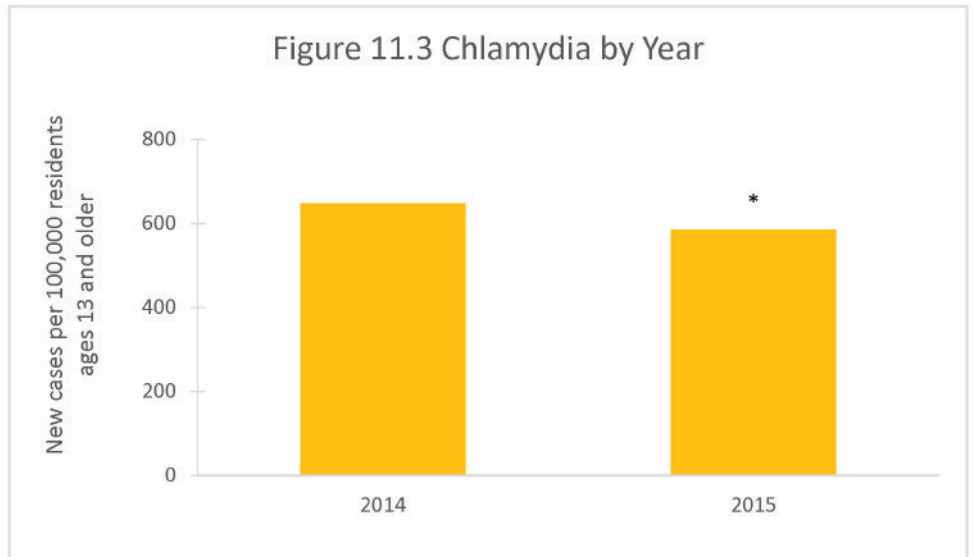


* Statistically significant change over time

DATA SOURCE: Youth Risk Behavior Survey (2007, 2009, 2011, 2013, 2015), Centers for Disease Control and Prevention and Boston Public Schools

In 2015, 65% of sexually active Boston public high school students used a condom during the last time they had sex. Between 2007 and 2015, this percentage decreased over time.

In 2015, the incidence rate for chlamydia was 585.3 new cases per 100,000 residents ages 13 and older. The incidence rate was 10% lower in 2015 compared with 2014.

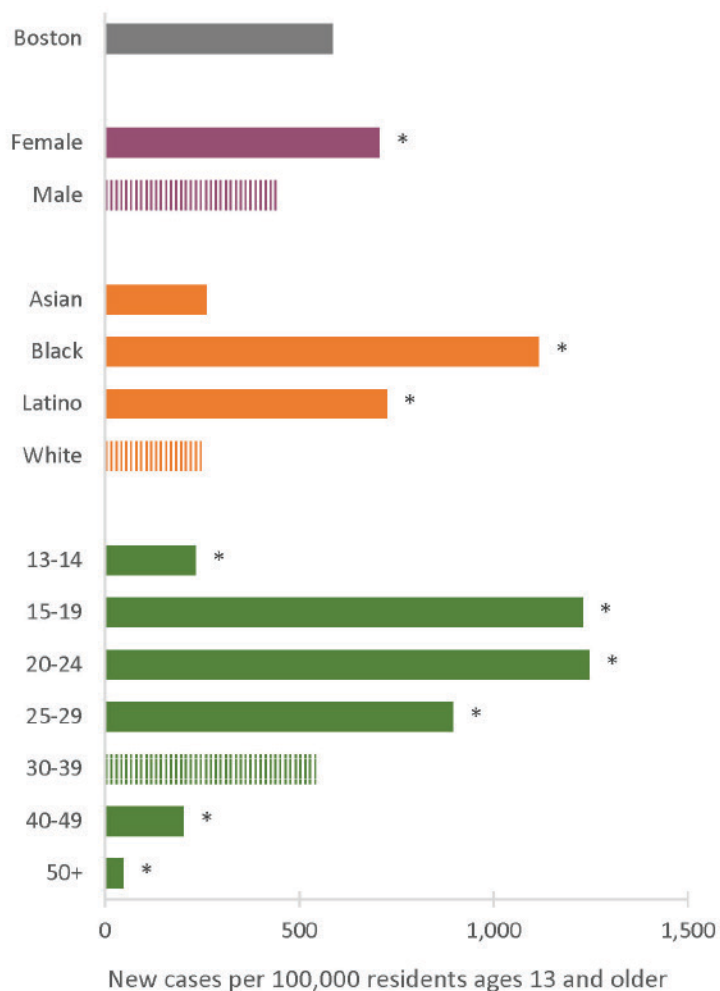


* Statistically significant change over time

DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission



Figure 11.4 Chlamydia by Selected Indicators, 2015



In 2015, there were 585.3 new cases of chlamydia per 100,000 residents ages 13 and older. The incidence rate for females (706.9) was 58% higher than the rate for males (446.3). Black (1,116.2) and Latino (725.7) residents experienced higher rates of chlamydia with incidence rates 4.5 times and almost 3 times, respectively, the rate of White residents (248.5).

The incidence rate for chlamydia was higher among residents ages 15-19 (1,229.8), 20-24 (1,246.3), and 25-29 (895.4) compared with residents ages 30-39 (541.4). The incidence rate was lower for residents ages 13-14 (233.8), 40-49 (202.8), and 50 and older (47.7) compared with residents ages 30-39.

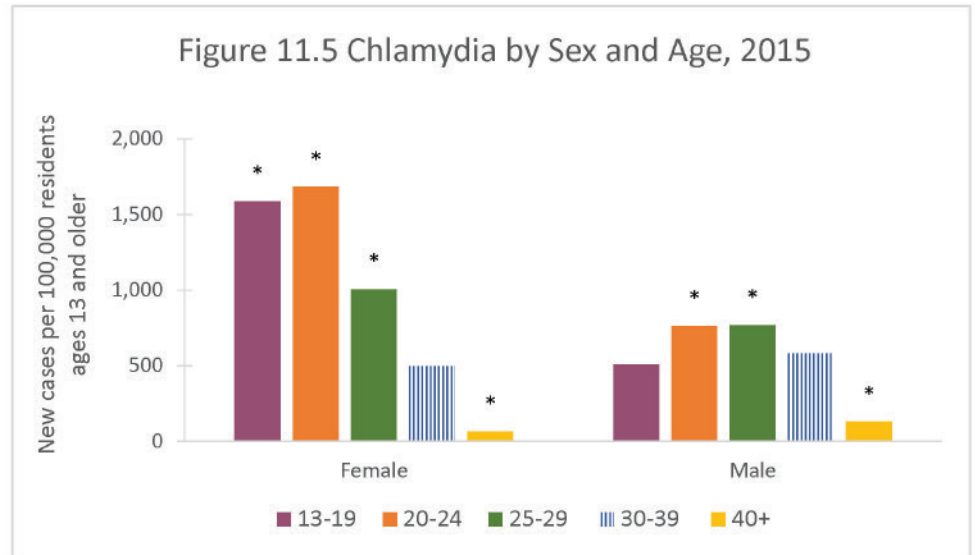
* Statistically significant difference when compared to reference group

NOTE: Bars with patterns indicate the reference group within each selected indicator.
 DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

Among females, the incidence rate for chlamydia was 3.2, 3.4, and 2.0 times higher respectively, for females ages 13-19 (1,590.2 new cases per 100,000 residents), 20-24 (1,682.7), and 25-29 (1,006.5) compared with those ages 30-39 (496.3). The incidence rate for females ages 40 and older (65.0) was 87% lower than that of females ages 30-39.

Among males, the incidence rate of chlamydia was 30% higher for residents ages 20-24 (762.5), 31% higher for residents ages 25-29 (768.1), and 78% lower for residents age 40 and older (129.4) compared with those ages 30-39 (584.7).

Figure 11.5 Chlamydia by Sex and Age, 2015

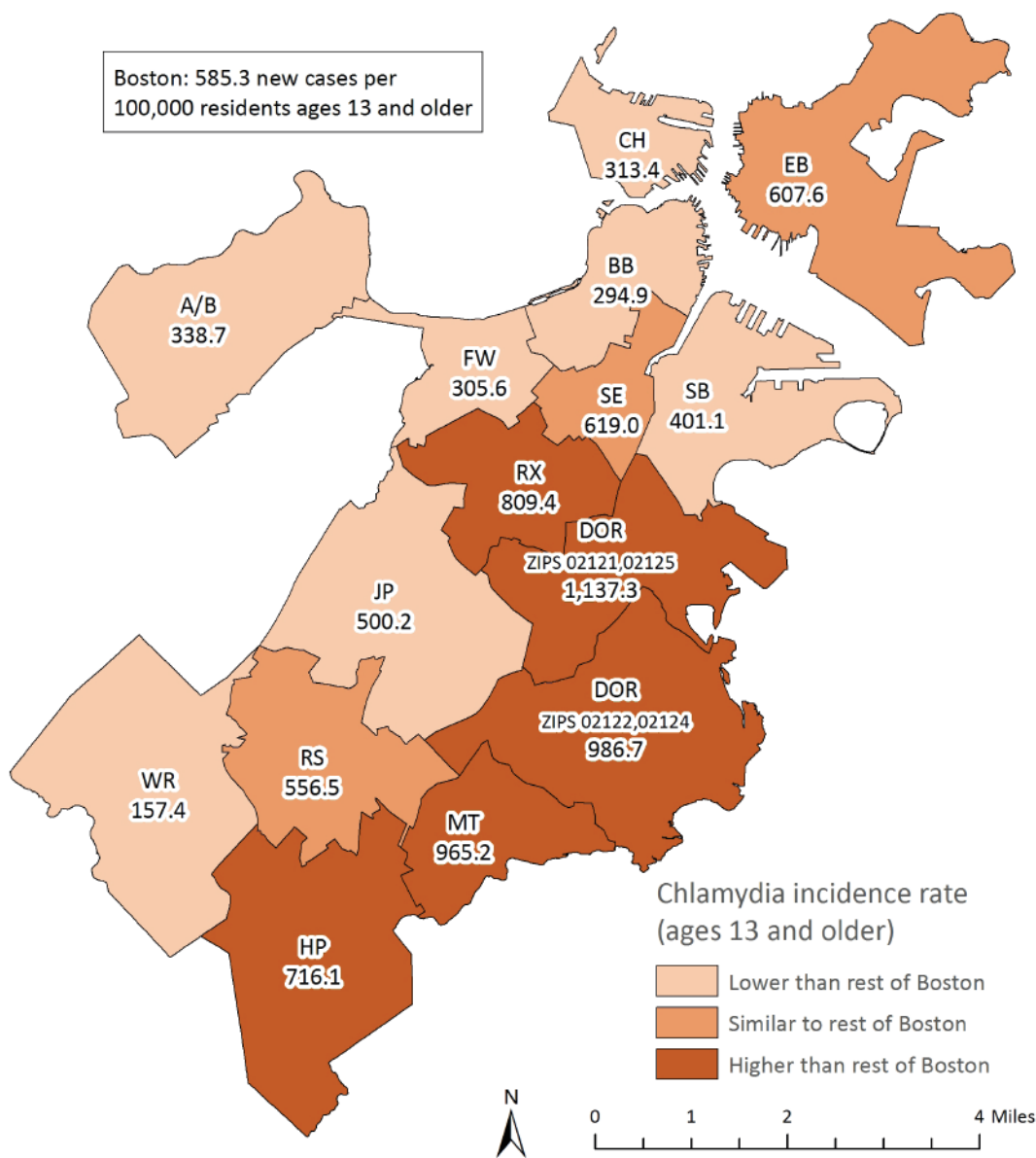


* Statistically significant difference when compared to reference group

NOTE: Bars with patterns indicate the reference group within each selected indicator.
 DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission



Figure 11.6 Chlamydia Incidence by Neighborhood, 2015



NOTE: "BB" includes the Back Bay, Beacon Hill, Downtown, the North End, and the West End. "SE" includes the South End and Chinatown.

DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

In 2015, the incidence rate for chlamydia among Boston residents ages 13 and older was 585.3 new cases per 100,000 residents. The rate of chlamydia was higher among residents in Dorchester (zip codes 02121, 02125), Dorchester (zip codes 02122, 02124), Hyde Park, Mattapan, and Roxbury compared with the rest of Boston. The rate of chlamydia was lower among residents in Allston/Brighton, Back Bay, Charlestown, Fenway, Jamaica Plain, South Boston, and West Roxbury compared with the rest of Boston.

Gonorrhea

Gonorrhea is a sexually transmitted infection caused by the bacterium *Neisseria gonorrhoea*. It is the second most commonly reported communicable disease in the U.S. (after chlamydia) (15). In 2015, the rate of gonorrhea was 124 per 100,000 people, an increase of 13% since 2014 (3). There was an increase in the rate among both men and women from 2014 to 2015; however, there was a larger increase among males. The rate of gonorrhea also increased in people in every age group among those ages 15 years and older during 2014–2015 (3). As you will see in the following section, trends in gonorrhea infection are slightly different in Boston as compared to the nation as a whole.

Symptoms and health effects

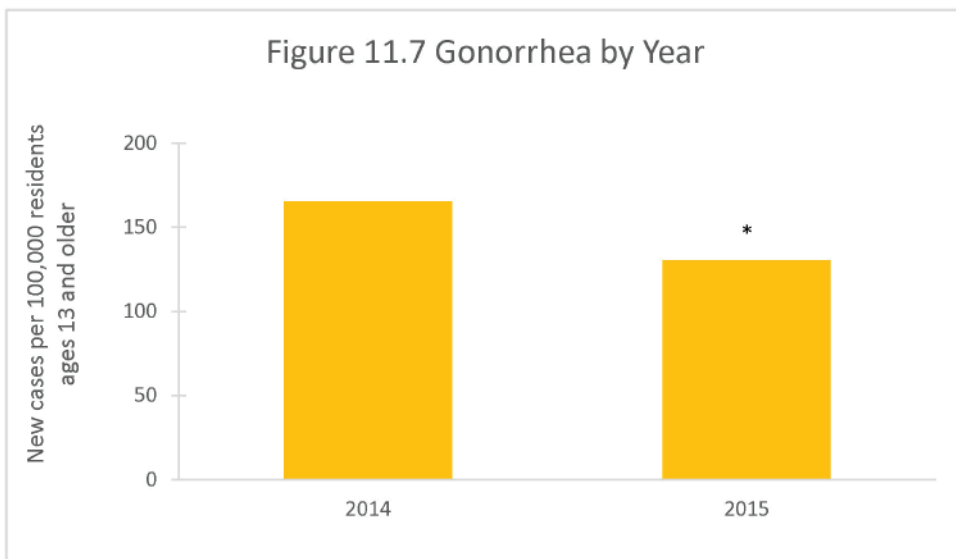
Many infections are asymptomatic; however, symptoms can include sore throat, painful urination, or abnormal vaginal/urethral discharge. Symptoms among women are generally mild and may be mistaken for bladder or vaginal infections. Men sometimes experience testicular pain or pain with urination. If left untreated, gonorrheal infection can lead to several serious complications including joint infections, pelvic inflammatory disease, infertility, and ectopic pregnancies. Transmission of infection to newborns is possible during childbirth, which can result in blindness, joint infection, and blood infection. In addition, people with untreated gonorrhea are at higher risk of becoming infected with HIV (16).

Screening and treatment

The prevalence of gonorrhea varies widely among communities and populations. In Boston, healthcare providers are urged to consider local patterns of infection when making screening decisions, including targeted screening of all sexually active women under age 25, those who have unprotected sex with multiple partners, and pregnant women (2).

A laboratory test is usually necessary to diagnose gonorrhea (16). Gonorrhea can be effectively treated with antibiotics. Evidence indicates that patients with gonorrhea are frequently co-infected with chlamydia. For this reason, CDC recommends treating both conditions simultaneously (2). Many strains of gonorrhea have developed resistance to antibiotics, making it even more important to be retested for gonorrhea following treatment (16).

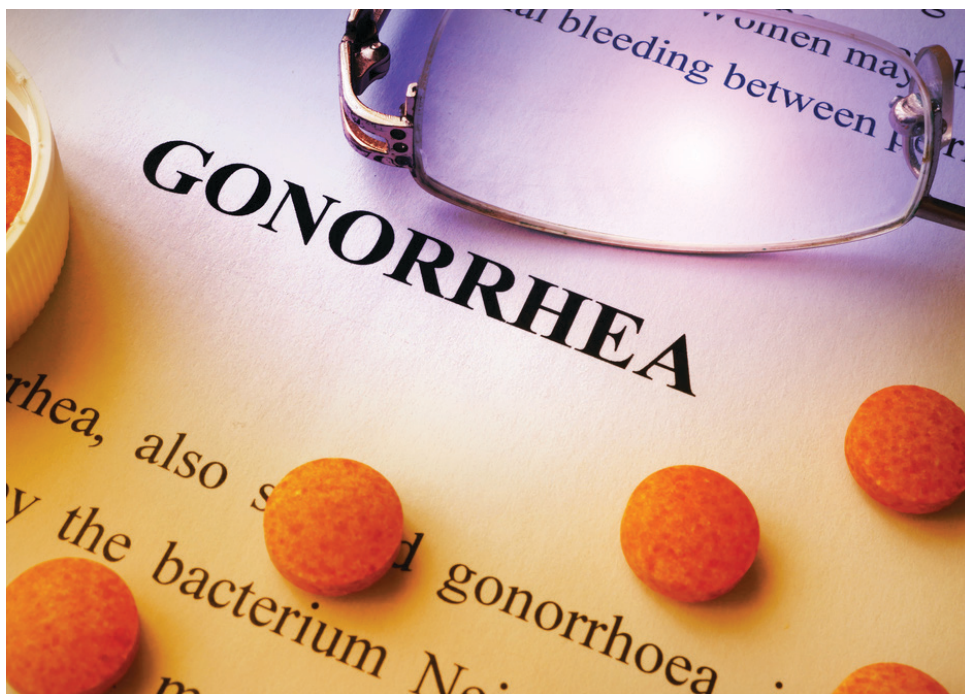
Figure 11.7 Gonorrhea by Year



* Statistically significant change over time

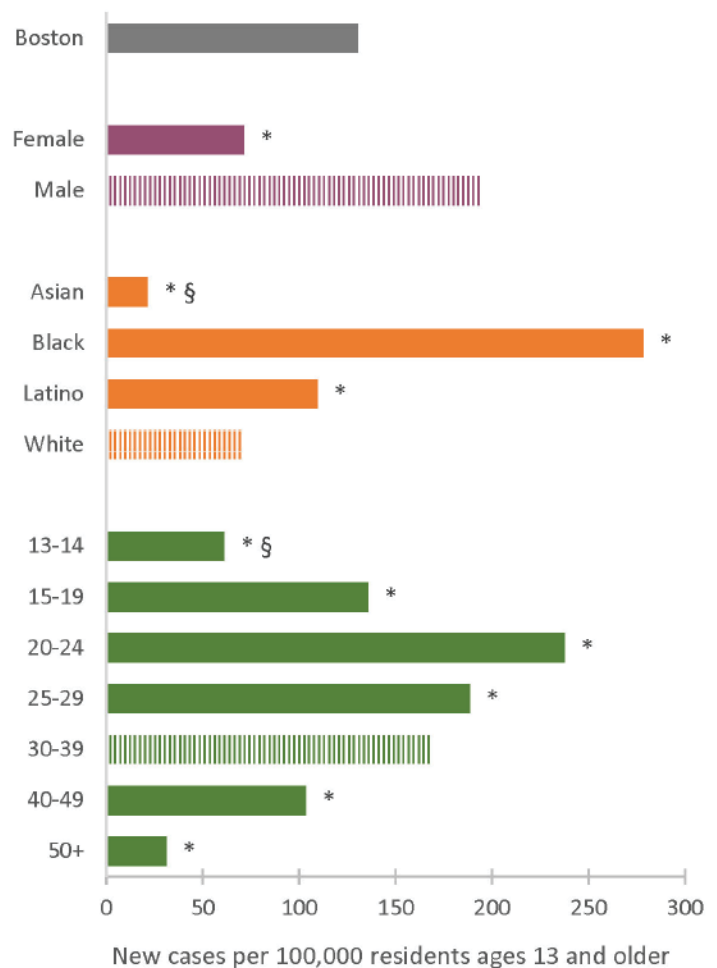
DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

In 2015, the incidence rate for gonorrhea was 130.2 new cases per 100,000 residents ages 13 and older. The incidence rate was 21% lower in 2015 compared with 2014.



In 2015, there were 130.2 new cases of gonorrhea per 100,000 residents ages 13 and older. The incidence rate for females was 63% lower than the rate for males. Black and Latino residents experienced incidence rates of gonorrhea, 278.4 and 109.5 respectively, that were higher than that of White residents (70.4), while the rate for Asian residents (21.5) was lower than that of White residents. The rate for Black residents was 4.0 times the rate of White residents. The rate for Latino residents was 56% higher, and the rate for Asian residents was 70% lower than White residents. The incidence rate was highest among residents ages 20-24 (237.5) with a rate 41% higher than the rate for residents ages 30-39 (168.6). Compared with residents ages 30-39, the incidence rate for gonorrhea was lower for residents ages 13-15 (61.0), 40-49 (103.5) and 50 and older (31.2).

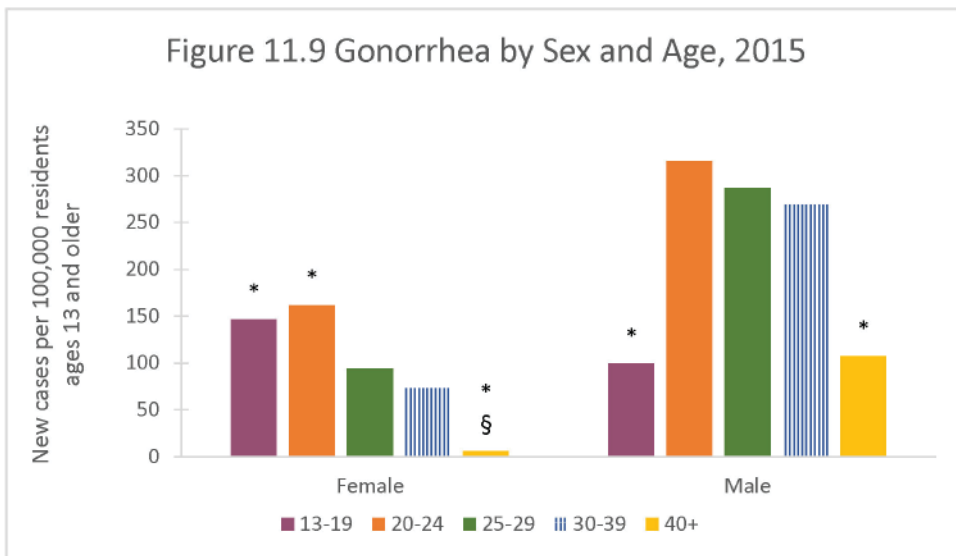
Figure 11.8 Gonorrhea by Selected Indicators, 2015



* Statistically significant difference when compared to reference group
 § Rates are based on 20 or fewer cases and should be interpreted with caution.

NOTE: Bars with patterns indicate the reference group within each selected indicator.
 DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

Figure 11.9 Gonorrhea by Sex and Age, 2015



* Statistically significant difference when compared to reference group
 § Rates are based on 20 or fewer cases and should be interpreted with caution.

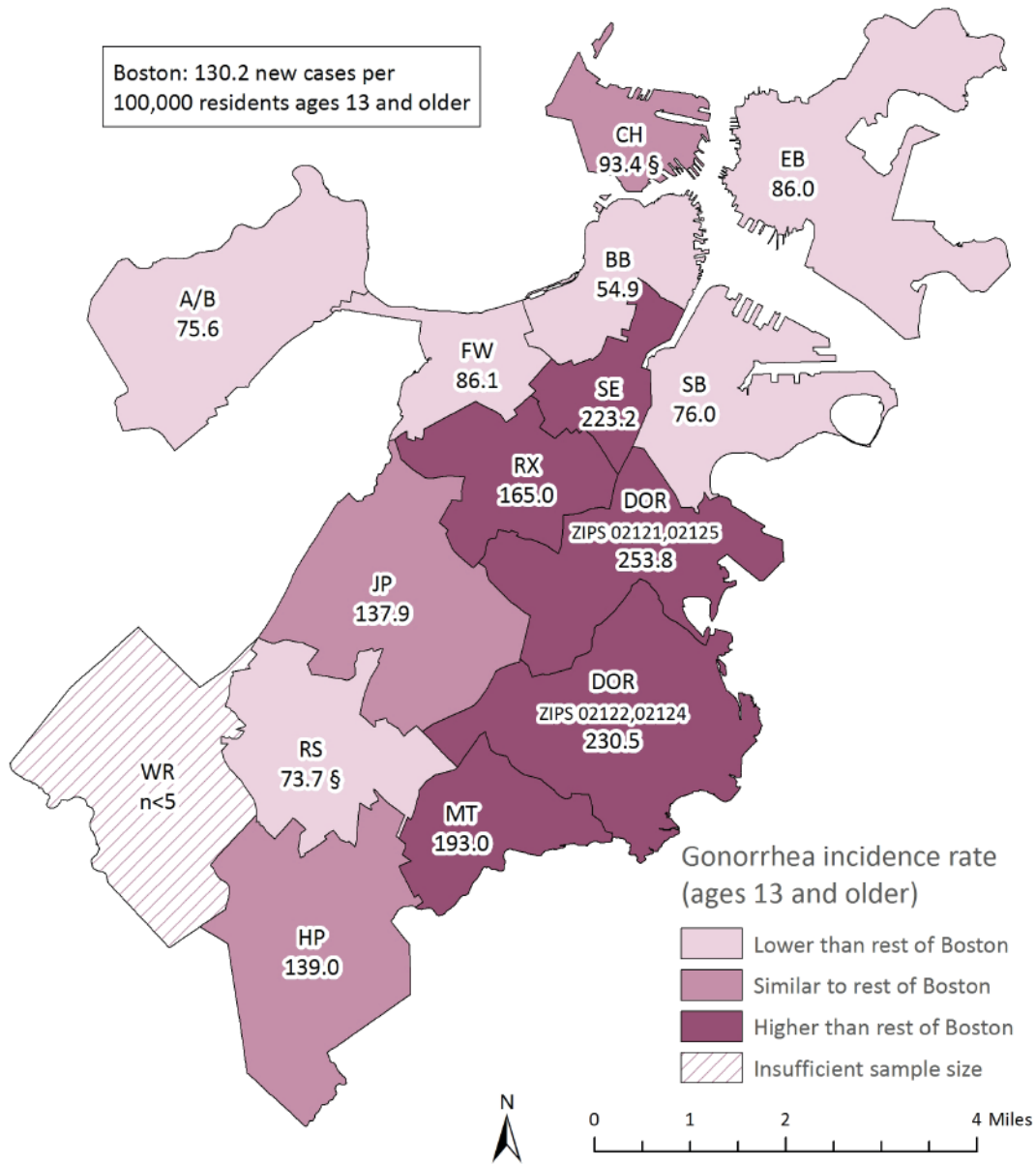
NOTE: Bars with patterns indicate the reference group within each selected indicator.
 DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

Among females, the incidence rate for gonorrhea was 2.0 and 2.2 times higher respectively, for residents ages 13-19 (146.8 new cases per 100,000 residents) and 20-24 (161.8) compared with those ages 30-39 (73.7). The incidence rate for females ages 40 and older (6.3) was 91% lower than that of females ages 30-39.

Among males, the incidence rate of gonorrhea was 63% and 60% lower respectively, for residents under age 20 (99.5) and age 40 and older (107.5) compared with those ages 30-39 (269.3).



Figure 11.10 Gonorrhea Incidence by Neighborhood, 2015



§ Rates are based on 20 or fewer cases and should be interpreted with caution.

NOTE: "BB" includes the Back Bay, Beacon Hill, Downtown, the North End, and the West End.
 "SE" includes the South End and Chinatown.

DATA SOURCE: Infectious Disease Bureau, Boston Public Health Commission

In 2015, the incidence rate for gonorrhea among Boston residents was 130.2 new cases per 100,000 residents ages 13 and older. The rate of gonorrhea was higher among residents in Dorchester (zip codes 02121, 02125), Dorchester (zip codes 02122, 02124), Mattapan, Roxbury, and the South End compared with the rest of Boston. The rate of gonorrhea was lower among residents in Allston/Brighton, Back Bay, East Boston, Fenway, Roslindale, and South Boston compared with the rest of Boston.

HIV/AIDS

Human immunodeficiency virus (HIV) is a virus that affects the CD4 cells of the immune system and can eventually lead to acquired immunodeficiency syndrome (AIDS). Overtime HIV destroys the CD4 cells (or T cells), preventing the body from fighting off infections. Once infected, the body does not get rid of HIV. This means that HIV is considered an incurable infection (17).

Today, over a million people in the U.S. are living with HIV, and nearly a half million have developed AIDS. About 40,000 infections are diagnosed each year (18). Between 2005 and 2014, the annual number of new HIV diagnoses declined 19% (18). It is estimated that about 1 in 8 individuals with HIV are unaware they have the infection, the majority being those between the ages of 13-24 years (19).

In July 2015, the National HIV/AIDS Strategy (NHAS) was updated to provide new goals for the next five years, including decreasing the number of new HIV diagnoses by at least 25% by the year 2020. The NHAS will measure progress towards decreasing new HIV infections by using HIV diagnosis as an indicator (18).

Transmission and progression of disease

Transmission of HIV occurs when bodily fluids from an infected person come into contact with mucous membranes (found inside the vagina, penis, rectum, or mouth), damaged tissue, or blood stream of an uninfected person. Examples of bodily fluids that carry the virus include blood, semen, vaginal fluids, rectal fluids, and breast milk (20).

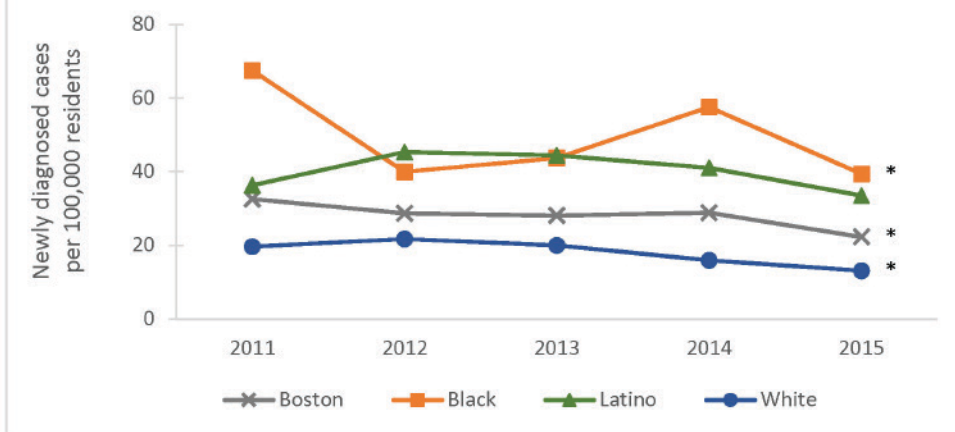
Within two to four weeks of HIV infection, acute retroviral syndrome can develop, which may or may not have symptoms similar to a common cold (17). During this early stage of infection, large amounts of HIV are produced in the body and one's ability to spread the infection is very high. Eventually, the immune system will stabilize the amount of virus in the body. The next stage of HIV infection is known as clinical latency, in which HIV reproduces at very low levels. Depending upon response to treatment, clinical latency can last several decades. Over time, the viral load in the body begins to rise again, and the CD4 cell count begins to drop. This final stage of HIV infection is known as AIDS when the number of CD4 cells falls below 200 cells per cubic millimeter of blood [200 cells/mm³] (normal CD4 counts are between 500 and 1,600 cells/mm³) (17). AIDS can also be defined by a person developing one or more opportunistic infections. Opportunistic infections take advantage of the weakened immune system and cause serious health consequences in people with HIV infection. Examples of opportunistic infections include fungal infections, tuberculosis, and pneumonia (17).

Prevention, screening and treatment

Prevention of HIV infection is possible through consistent condom use during sex, refraining from needle sharing during intravenous drug use, and avoiding breastfeeding if infected. CDC recommends HIV screening for all persons who seek evaluation and treatment of STIs (21). Screening can also be performed at home with HIV test kits that are available over-the-counter. Although there is no cure for HIV infection, people can live long, productive lives with antiretroviral therapy (ART) and preventive treatment for opportunistic infections (17).



Figure 11.11 Newly Diagnosed Cases of HIV by Race/Ethnicity and Year of Diagnosis



* Statistically significant change over time

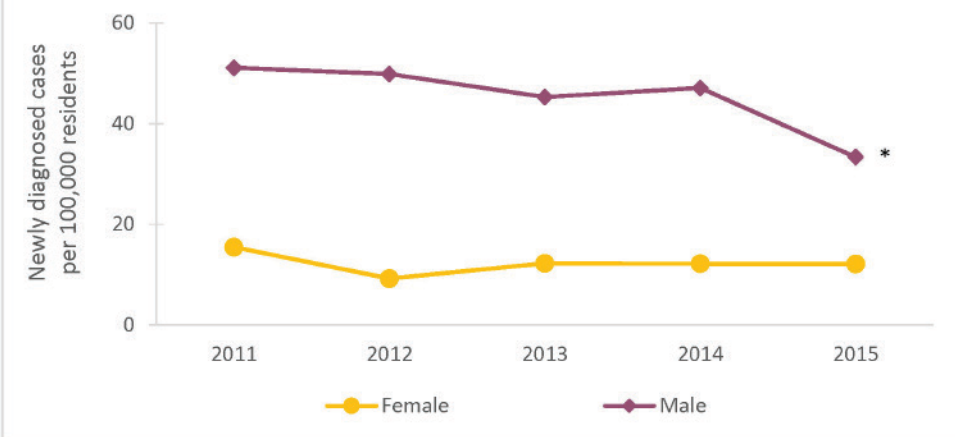
NOTE: Rates are not presented due to a small number of cases for Asian residents. Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

In 2015, the incidence rate for newly diagnosed HIV was 22.3 new cases per 100,000 Boston residents. Between 2011 and 2015, the incidence rate decreased by 25% for Boston overall. During the same time period, the incidence rate decreased for both Black and White residents, 27% and 34%, respectively. There was no significant change over time for Latino residents.

In 2015, the incidence rate for Black residents (39.4) was 3.0 times the rate for White residents (13.1). The incidence rate for Latino residents (33.5) was 2.6 times the rate for White residents.

Figure 11.12 Newly Diagnosed Cases of HIV by Sex and Year of Diagnosis



* Statistically significant change over time

NOTE: Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

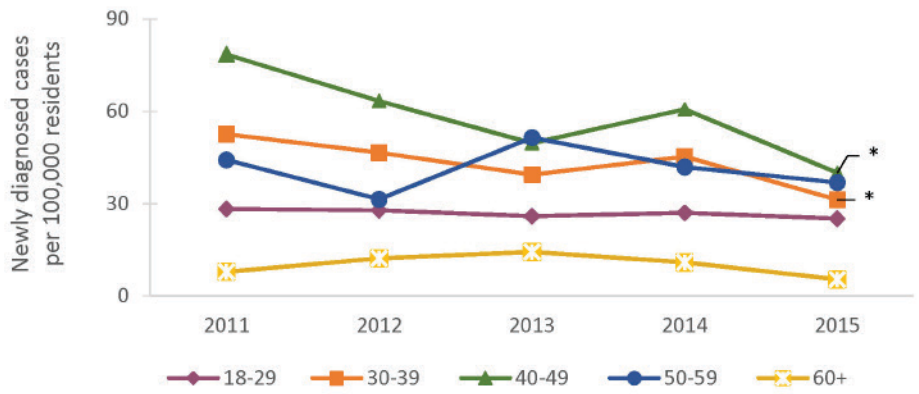
Between 2011 and 2015, the incidence rate for newly diagnosed HIV among male residents decreased by 29%. There was no significant change over time for female residents during the same time period.

In 2015, the HIV incidence rate for female residents was 12.1 new cases per 100,000 residents, which was 64% lower than that of male residents (33.3).

Between 2011 and 2015, the incidence rate for newly diagnosed HIV decreased by 34% for residents ages 30-39 and by 42% for residents ages 40-49.

In 2015, the rate for 18- to 29-year-olds was 25.2 new cases per 100,000 residents. In comparison to those ages 18-29, the incidence rate was 59% higher for 40- to 49-year-olds (40.0) and 79% lower for those ages 60 and older (5.4).

Figure 11.13 Newly Diagnosed Cases of HIV by Age at Diagnosis and Year of Diagnosis



* Statistically significant change over time

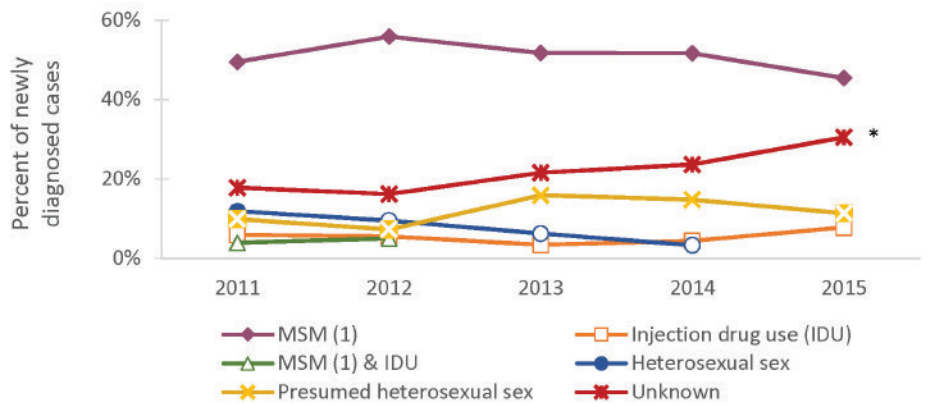
NOTE: HOLLOWED-OUT symbols represent rates based on 20 or fewer cases and should be interpreted with caution. Rates are not presented due to a small number of cases for residents ages 0-17. Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

From 2011 to 2015, HIV infections acquired from an unknown mode of transmission increased by 79%.

In 2015, the mode of transmission of 45% of all newly diagnosed cases of HIV in Boston was men who have sex with men (MSM). Thirty-one percent of cases were reported as an unknown mode of transmission, 11% were through presumed heterosexual sex, and 8% were from injection drug use.

Figure 11.14 Newly Diagnosed Cases of HIV by Mode of Transmission and Year of Diagnosis

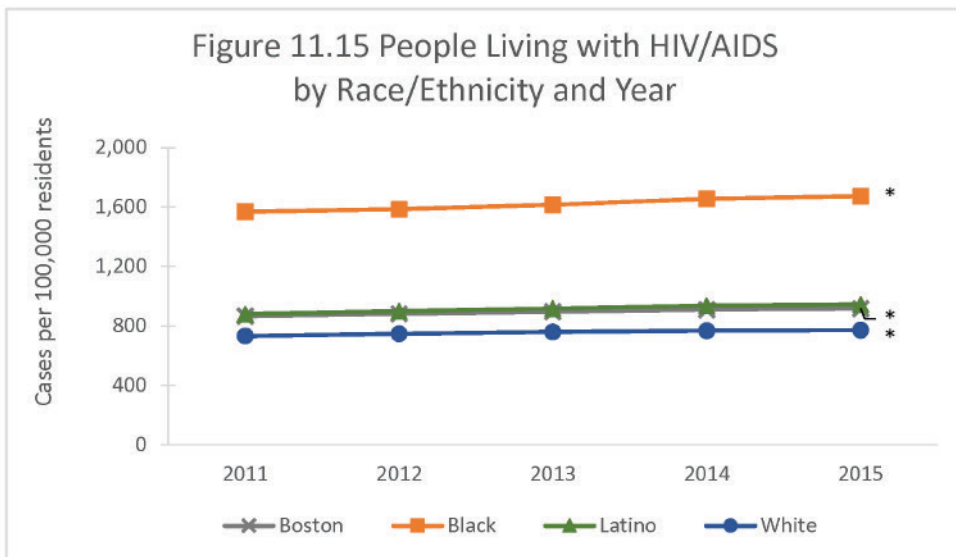


* Statistically significant change over time
(1) Men who have sex with men

NOTE: HOLLOWED-OUT symbols represent percentages based on 20 or fewer cases and should be interpreted with caution. Percentages are not presented due to a small number of cases for MSM & IDU transmission for 2013-2015 and heterosexual sex transmission for 2015. Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

Figure 11.15 People Living with HIV/AIDS by Race/Ethnicity and Year



* Statistically significant change over time

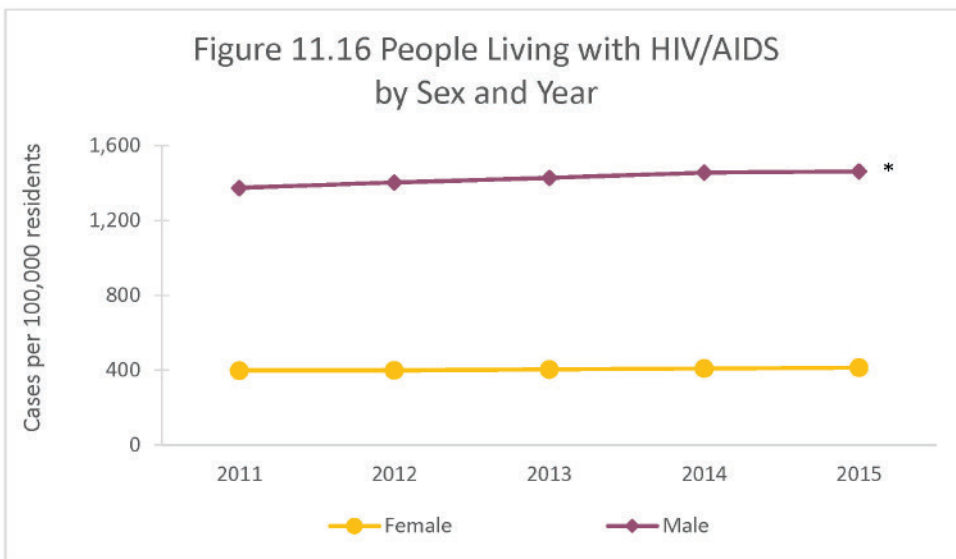
NOTE: Rates are not presented due to a small number of cases for Asian residents. Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

In 2015, the prevalence rate for people living with HIV/AIDS in Boston was 915.4 cases per 100,000 Boston residents. Between 2011 and 2015, the rate increased by 6% for Boston overall. During the same time period, the rate increased 7% for Black residents and 6% for White residents. There was no significant change over time for Latino residents.

In 2015, the prevalence rate for Black residents (1,672.4) was 2.2 times the rate for White residents (771.2). The prevalence rate for Latino residents (944.0) was 1.2 times the rate for White residents.

Figure 11.16 People Living with HIV/AIDS by Sex and Year



* Statistically significant change over time

NOTE: Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health

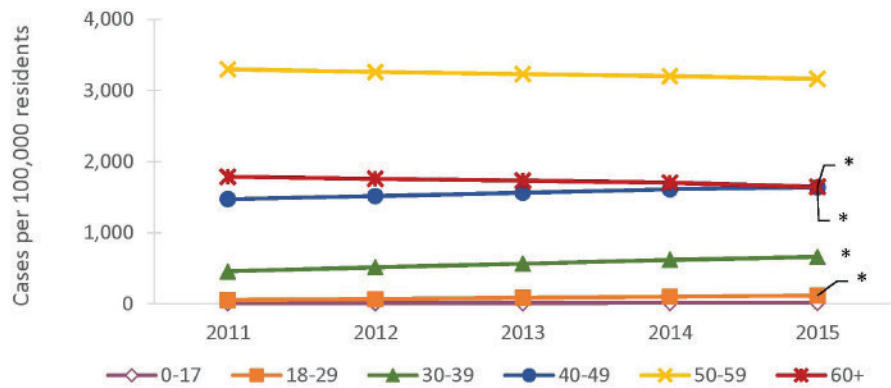
Between 2011 and 2015, the prevalence rate for male residents living with HIV/AIDS increased by 7%. There was no significant change over time for female residents.

In 2015, the rate of HIV/AIDS for female residents was 414.5 cases per 100,000 residents, which was 72% lower than the rate for male residents (1,461.9).

Between 2011 and 2015, the prevalence rate for people living with HIV/AIDS increased for residents ages 18-29, 30-39, and 40-49. The greatest change over time was among the 18- to 29-year-olds with an increase of 109%. The rate decreased by 8% for residents ages 60 and older.

In 2015, the rate of HIV/AIDS among 18- to 29-year-olds was 118.3 cases per 100,000 residents. In comparison to residents ages 18-29, the rate was higher for all of the older age groups. The greatest difference was seen among residents ages 50-59 (3,163.9) with a rate 27 times the rate for 18- to 29-year-olds. The rate of HIV/AIDS among residents under age 18 (12.3) was 90% lower than the rate for 18- to 29-year-olds.

Figure 11.17 People Living with HIV/AIDS by Age and Year



* Statistically significant change over time

NOTE: HOLLOWED-OUT SYMBOLS represent rates based on 20 or fewer cases and should be interpreted with caution. Prisoners were excluded from these data.

DATA SOURCE: HIV/AIDS Surveillance Program, Massachusetts Department of Public Health



Summary

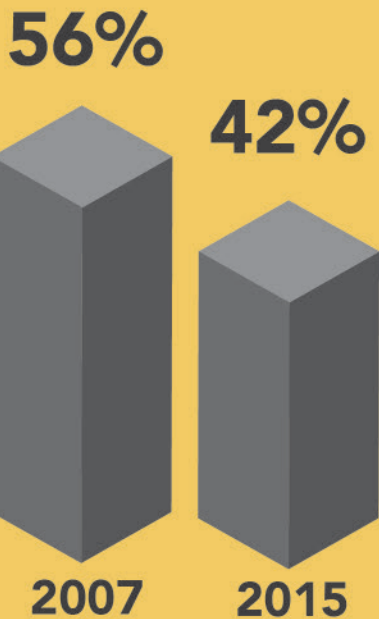
The City of Boston experienced significant reductions in the incidence rates for chlamydia and gonorrhea from 2014 to 2015 and for HIV from 2011 to 2015. The reduction in the rate of HIV is explained by the 27% decline in the incidence rates observed for Black residents and the 34% decline for White residents, across the same time period. However, racial and ethnic inequities continue to persist, as the incidence rates for chlamydia, gonorrhea, and HIV in 2015 among Boston residents were consistently higher in Black and Latino residents in comparison with White residents. Sex and age inequities also vary by health outcome. Among Boston residents, incidence rates for both chlamydia and gonorrhea in 2015 were higher in individuals ages 20-24 in comparison with individuals ages 30-39. While the incidence rate for HIV from 2011 to 2015 declined by 29% for men and by 42% for individuals ages 40-49, these subgroups continued to have higher incidence rates of HIV in 2015 in comparison with women and individuals ages 18-29. At the neighborhood level, Dorchester (zip codes 02121, 02125), Dorchester (zip codes 02122, 02124), Mattapan, and Roxbury experienced elevated incidence rates for both chlamydia and gonorrhea.

Findings from the 2007 to 2015 Boston Youth Risk Behavior Summary indicate that there was a significant reduction in the percentage of Boston public high school students that reported ever having sex. Significant reductions were also observed for both Black and Latino students over the same time period. Among all Boston public high school students, condom use during the last time having sex also decreased over the same time period. Reducing the risk of becoming infected should remain the goal of STI prevention strategies. Strategies should include efforts to increase the use of condoms.

Sexual Health



% of Boston public high school students who reported ever having sex decreased



10% decrease in chlamydia incidence rate



21% decrease in gonorrhea incidence rate



25% decrease in HIV incidence rate from 2011 to 2015

Our Point of View: Thoughts from public health

Striving for sexual health

By Stewart Landers
JSI Research & Training Institute

Let's talk about sex, and more importantly sexual health. According to the World Health Organization, "Sexual health is a state of physical, mental and social well-being in relation to sexuality. It 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."¹ Whatever your orientation – straight, gay, lesbian, bisexual, transgender, queer, or asexual – it is important to strive for sexual health and well-being. Becoming infected with a sexually transmitted infection (STI) can have a big impact on the health and wellbeing of sexually active residents of the city of Boston.

For many years, Chlamydia² has been the most commonly occurring STI in Boston. It affects women more than men, with the highest rates for both men and women in people ages 15-19. Sexual contact that is vaginal, oral, or anal (with or without ejaculate/semen) can transmit the disease, and a pregnant mother with chlamydia can transmit the disease to her newborn child. The good news is condoms, used correctly every time, can prevent transmission, and Chlamydia is treatable. Remember – Chlamydia often has no symptoms so it's important to detect and treat³ Chlamydia early to prevent any side effects.

The second most commonly transmitted STI among Boston residents is gonorrhea. In general, gonorrhea is more common among males. However, in Boston, young females (ages 15-19) have higher rates than young males. Gonorrhea rates have been trending slightly higher in the city and, disturbingly, there has been a steady increase across the United States in antibiotic resistant gonorrhea, potentially making some cases more difficult to treat. If you are getting checked out for either Chlamydia or gonorrhea, you should probably get checked for both at the same time. While syphilis is less common than either Chlamydia or gonorrhea, it has also been increasing over the past decade, especially in some of the nation's largest cities. It is present in Boston, and male-to-male sexual contact has been a major driver of increased syphilis cases.⁴

Lastly HIV and AIDS has been a serious issue affecting sexual health and well-being of many Bostonians since the early 1980s. While no cure exists, there have been major advances in both prevention and treatment of the disease that has substantially changed its impact. For example, pre-exposure prophylaxis or "PrEP" is a pill that can be taken daily by someone at risk for HIV infection. PrEP can greatly reduce the chances of becoming infected with HIV. Any STI clinic or medical provider can give you more information about PrEP and provide help deciding if it's right for you⁵. Treatment for HIV can be very effective, especially treatment that begins before the virus causes serious health issues. Get screened for HIV if you are sexually active or use needles to inject drugs. If you are HIV positive, be sure to see a medical provider and get treatment for HIV and AIDS and stay on your medications.⁶ All people deserve a healthy and fulfilling sex life. By becoming knowledgeable and taking action to prevent or treat STIs, it is possible.

¹ http://www.who.int/topics/sexual_health/en/ Accessed online 3/3/17

² <https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm> Accessed online 3/3/17

³ <https://www.cdc.gov/std/gonorrhea/arg/default.htm> Accessed online 3/7/17

⁴ <https://www.cdc.gov/std/syphilis/stdfact-msm-syphilis.htm> Accessed online 3/6/17.

⁵ <http://www.bphc.org/whatwedo/infectious-diseases/Infectious-Diseases-A-to-Z/Documents/Fact%20Sheet%20Languages/PrEP/English.pdf> Accessed online 3/7/17.

⁶ <http://www.bphc.org/whatwedo/infectious-diseases/Infectious-Diseases-A-to-Z/Pages/HIV.aspx> Accessed online 3/7/17.

Our Point of View: Thoughts from a community resident

A second chance at life

By a community resident

I'm a 53-year-old, college-educated, bi-sexual, Black man. I was diagnosed with HIV in 1999 while I was incarcerated. I was afraid to seek treatment at first because I didn't want anyone to know. I worried if people saw me they would know I was infected. There was still a lot of stigma then.

At the time, I was still on the down low – meaning nobody knew about my sexuality or my status. I had a pretty chaotic childhood. I grew up in the suburbs. We were only the second black family to move there, which was confusing. My dad used to beat my mom up. He was an alcoholic, but I didn't know that then. I was literally afraid to share my true identity, so I turned to drugs.

I spent years in and out of drug treatment and incarceration. My drug addiction and crime went hand in-hand. There were times I tried to take my own life because I couldn't understand why this had happened to me. Eventually jail became my safe haven – no access to drugs, and someone to give me my HIV meds and make sure I couldn't hurt myself. I would commit crimes just to go back.

Eventually life got too complicated. I didn't want to keep living like that. A friend told me about an HIV clinic at Massachusetts General Hospital (MGH). Before that I didn't like going to doctors because they would relate everything back to my HIV, whether it was relevant or not. I used to hold back a lot because I was raised that you don't share your business outside the family, but I met a doctor I really liked at MGH and told him everything.

Slowly I started to open up and began to understand my disease. I started working with people who had similar experiences with HIV and incarceration. I realized that I could help myself by helping them. Before that I didn't realize there were other people out there who were like me. I thought I was alone.

Today, I've been sober for 18 months, and I take my meds every day. I realize now life has more to offer – I have more to offer. I started going back to church. I believe everything happens for a reason. I should have been dead. I almost died twice already and was brought back to life. I'm here for a reason: to share my experience and let people know my goals and aspirations.

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