

**October 2019**

## Why are gay and bisexual teens not taking PrEP to Prevent HIV?

Every 30 hours in the U.S., a gay or bisexual adolescent boy under the age of 18 is diagnosed with HIV. Gay and bisexual boys are disproportionately affected by HIV—accounting for almost two-thirds of new infections among adolescents. Young gay and bisexual men of color are hit especially hard, accounting for over three-quarters of these infections. HIV rates are rising among Latino adolescent boys, and 1 in 2 black men who have sex with men are expected to become HIV positive in their lifetimes.

One tool can help curb the HIV epidemic in teens—a once-daily pre-exposure prophylaxis (PrEP) pill can prevent HIV from taking hold and spreading throughout the body. The problem is that barely any gay or bisexual teen boys are using it.

In May 2018, the Food and Drug Administration approved Truvada which combines two anti-HIV drugs—tenofovir and emtricitabine—for PrEP to prevent HIV in teenagers weighing at least 77 pounds (Truvada was approved for HIV prevention among adults in 2012). PrEP is safe and has limited side effects. It is highly effective, and if taken as prescribed, it can reduce sexual transmission of HIV in gay and bisexual men by 92 percent—possibly even higher with perfect use.

So why aren't teens using it?

To begin with, most teens are not aware of PrEP. In 2015, only 16 percent of gay and bisexual teen boys knew about PrEP. In a spring 2018 study, awareness had risen to 55 percent. When they do learn about PrEP, they report high levels of interest.

Stigma plays a role in the lack of adoption of PrEP. The unfounded perception that PrEP users are promiscuous is a well-known obstacle to its acceptability in adults. It's possible that perception also exists in

## ***"When they do learn about PrEP, [gay and bisexual teen boys] report high levels of interest."***

teens. Structural obstacles also restrict access. PrEP is covered by health insurance, yet teens whose parents don't approve of their sexual orientation don't want to be "outed" by an insurance bill. Without insurance, PrEP is prohibitively expensive, approximately \$2,000 per month though medication assistance programs can defray some costs.

Other barriers that can make accessing PrEP challenging are finding a doctor who knows about PrEP and is willing to prescribe it; lack of transportation to get to routine doctor visits required when starting PrEP; and difficulty scheduling those visits outside of school hours.

We talk about one day achieving an HIV-free generation. To do so, we all need to be aware of and realistic about teen sexual activity, and honest, open conversations must be had about sex at a younger age. It is the responsibility of parents, health care providers, and public health professionals to equip teens with information about PrEP as part of routine sex education and advocate for them to get PrEP if it's right for them. Until then, one of the most potent tools in the fight against HIV in vulnerable populations will remain tragically underused.

## **Naloxone-induced aggression and assault Separating myths from facts**

Recently, a passenger on a Delta flight from Boston to Los Angeles died from an apparent overdose, sparking widespread media attention attributing the death to a lack of naloxone on board.

Coverage of this incident prompted polarized responses across social media, including concern that naloxone administration can cause aggression in patients who receive it and increases risk of assault to bystanders, rescuers, or healthcare providers. While anecdotes were shared to justify this theory, there is little substantive data to corroborate it.

Treating patients with altered levels of consciousness—whether related to a drug overdose or other medical conditions such as low glucose—often involves working in close physical proximity with the patient. Although recent data demonstrates physical assault of EMS professionals is on the rise, decades of treating overdoses have shown no evidence attributing this increase to patients who use drugs and are properly administered naloxone. In addition, there isn't any known data linking the physical assault of EMS professionals to naloxone administrations outside hospital settings.

There is also little evidence to show adverse behavioral reactions to naloxone. A review of this life saving treatment found a less than 3% rate of behavioral disturbances. Naloxone is unlikely to cause adverse reactions, and with the development of the simpler intranasal naloxone, proper administration results in a more gradual emergence from the effects of opioids and less risk to rescuers or bystanders.

*\*Please note: It's really important to make sure that a person is actually overdosing and not in a heavy nod before administering naloxone. When administered as recommended (waiting 2-3 minutes before giving another dose if needed), aggressive physical and behavioral outcomes are statistically unlikely. It is also important that follow up medical attention is offered to patients who receive naloxone to address any withdrawal symptoms.*

After the in-flight incident, Delta said that starting this fall, they will make naloxone available in emergency medical kits. We have to assume that an overdose can happen anywhere, even at three thousand feet, so having naloxone readily available is another step in saving lives.

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Contact us to request training or technical assistance at [praxis@c4innovates.com](mailto:praxis@c4innovates.com).



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