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California Stories

STDs Are On The Rise

As reported by California Healthline | 4.18

In early April, California's Department of Public Health released its 2016 County Health Status Profiles. The report found that the incidence rate of chlamydia increased by 7 percent in 2012-2014 over 2009-2011. Gonorrhea incidence among males aged 15-44 increased by 54 percent and by 35 percent for females in the same age group.

We charted the department's historical data for reported cases and rates of chlamydia, gonorrhea and syphilis infections in California dating back to 1913:

[View the graphic.](#)

According to the U.S. Centers for Disease Control and Prevention, reported cases of chlamydia, gonorrhea and syphilis increased nationally in 2014 for the first time since 2006.

STDs continue to affect young people — particularly women — most severely, but increasing rates among men contributed to the overall increases in 2014 across all three diseases.

The chart below compares California incidence rates to national rates as reported by the CDC:

[View the graphic.](#)

April is STD Awareness Month, aimed at preventing some of the nearly 20 million new cases of sexually transmitted diseases that occur in the U.S. each year. The CDC is using the month to encourage individuals and health care providers to talk, test and treat.

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

California Legislature Advances Landmark Bill to Increase Awareness of PrEP and PEP

Bill Co-Sponsored by AIDS Project Los Angeles and the Los Angeles LGBT Center Ensures HIV-Negative Individuals Receive Information about PrEP and PEP During HIV Post-Test Counseling

Press Release, Los Angeles LGBT Center and AIDS Project Los Angeles | 4.20

Landmark legislation to boost awareness of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection was approved by the California Assembly Health Committee yesterday and will advance to the Assembly Appropriations Committee.

Co-sponsored by the Los Angeles LGBT Center and AIDS Project Los Angeles (APLA) and introduced by Assemblymember Mike A. Gipson (D-Carson), AB 2640 would ensure high-risk HIV-negative individuals receive information about all methods that reduce the risk of contracting HIV, including PrEP and PEP, during HIV post-test counseling.

“PrEP and PEP are highly effective interventions that could dramatically reduce new HIV infections in the state, but many people are still unaware that these new prevention methods even exist,” APLA CEO Craig E. Thompson said. “When someone receives an HIV-negative test result, they should also receive information about how to stay HIV-negative.”

PrEP is an HIV prevention strategy in which HIV-negative individuals take a daily medication to reduce their risk of becoming infected. PrEP has been shown to be up to 99% effective at preventing HIV transmission. PEP involves taking anti-HIV medications as soon as possible after a potential exposure to reduce the risk of becoming HIV-positive. According to a 2015 survey of gay and bisexual men by the California HIV/AIDS Research Program, only 1 in 10 respondents had ever used PrEP and nearly 85% had never talked to their doctor about PrEP.

“Alarming, awareness of PrEP and PEP is particularly low for those most at risk of HIV infection in California: Black and Latino men who are gay or bisexual,” Los Angeles LGBT Center Medical Director Dr. Robert Bolan said. “This bill is a common sense approach to ensure people receive information about how to protect themselves. It will also encourage more open dialogue between medical providers and patients regarding sexual health.”

The West Hollywood City Council recently voted to require that the city’s contracted providers of HIV testing provide information about PrEP during pre- and/or post-test counseling. However, there is currently no statewide requirement to provide information about any HIV prevention methods, including PrEP and PEP, during HIV post-test counseling.

“It is estimated that 1 in 2 Black gay men and 1 in 4 Latino gay men will be diagnosed with HIV in their lifetime if infection rates continue to rise. This is unconscionable. Women of color and transgender individuals are also among the groups at greatest risk for HIV,” Assemblymember Gipson said. “We now have effective tools like PrEP and PEP that can help end the HIV epidemic, but that won’t happen unless people know about them. We must do more to make sure that people know about all of the tools available to protect themselves, especially PrEP and PEP.”

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

National Stories

New HPV vaccine could curb cervical cancers and health costs if adopted widely

As reported by Medical News Today | 4.19

A Yale-led study finds that a new vaccine for human papillomavirus (HPV) would significantly reduce both cervical cancer incidence and healthcare costs if states coordinated policies to improve coverage.

The study was published April 18 by Proceedings of the National Academy of Sciences.

HPV, the most common sexually transmitted infection in the United States, is the primary cause of cervical cancer. A new vaccine available since 2015, Gardasil 9, provides protection against nine

different HPV types, including five cancer-causing types that were not included in older vaccines. A team of researchers at Yale School of Public Health and the University of Waterloo developed a transmission model to determine the potential impact of the vaccine on cervical cancer incidence and healthcare costs.

The novel model took into account several factors affecting HPV transmission and cervical cancer progression. It incorporated 10 HPV types, demographics, age, sexual behavior, as well as state-specific vaccine policy and migration patterns.

The researchers found that switching to Gardasil 9 would result in greater health benefits at the same or lower cost. Specifically, the new vaccine would decrease cervical cancer incidence by 73%, compared to 63% with the older vaccines, and reduce mortality by 49% versus 43%.

The study also determined that these improvements could be realized at the same or lower cost despite the higher per-dose cost of Gardasil 9. Notably, their finding of increased cost-effectiveness holds whether vaccination rates increase or stay the same, said first author David Durham, associate research scientist at the Center for Infectious Disease Modeling and Analysis (CIDMA) at Yale School of Public Health. "Adopting the new vaccine is always cost-effective relative to the old vaccines," he noted.

In addition, efforts to expand HPV vaccination, particularly in states with low coverage, could prevent even more cancers and deaths, said the researchers, adding that due to interstate migration, all states would benefit if they aligned vaccination policy. "The greatest benefits of HPV vaccination both in terms of cancer reduction and health care costs are realized when policy promoting vaccination is coordinated across states," said Alison Galvani, the Burnett and Stender Families Professor of Epidemiology and director of CIDMA.

Furthermore, increased funding to states could improve vaccine coverage and public health, the researchers noted. Durham pointed to funds provided by states and the Centers for Disease Control and Prevention's (CDC) Prevention and Public Health Fund. More resources "do lead to improvements in coverage," he said. "In terms of number of cancers averted per vaccine, there are decreasing marginal returns in states that already have high coverage. You get more bang for your buck by focusing first on states with lower coverage."

The CDC currently recommends vaccination for females aged 11-26 and males aged 11-21. Three doses are recommended for lasting protection against cervical cancer, the researchers said. HPV is common in both males and females, and can cause cancers of the anus, mouth/throat and penis in males.

Reference:

[National- and state-level impact and cost-effectiveness of nonavalent HPV vaccination in the United States](#)

Authors: David P. Durhama, Martial L. Ndeffo-Mbaha, Laura A. Skripa, Forrest K. Jonesa, Chris T. Bauchb, and Alison P. Galvania

Journal: *Proceedings of the National Academy of Sciences*

DOI: 10.1073/pnas.1515528113

Published online April 18, 2016

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

How your DNA influences your sex life

Karen Kaplan, Los Angeles Times | 4.18

Your DNA doesn't determine when you lose your virginity, but it may play a larger role in the matter than scientists had thought.

A new study identifies 38 specific places in the human genome that appear to be associated with the age at which people first had sex. These spots affect a range of genes, including some that seem to affect the timing of puberty and others that have been linked with risk-taking behavior.

Altogether, the influence of these DNA variants accounts for about one-quarter of the variation in how old people are when they have sex for the first time, according to the study published Monday in the journal *Nature Genetics*. Environmental and cultural factors, along with individual choice, explain the rest, the study authors said.

"While social and cultural factors are clearly relevant, we show that age at first sexual intercourse is also influenced by genes," John Perry, a researcher at the University of Cambridge in England, said in a statement.

Perry and his colleagues singled out these 38 pieces of DNA with the help of more than 125,000 contributors to the UK Biobank. Each of these volunteers -- all between the ages of 40 and 69 -- provided a blood sample for genetic analysis. They also reported how old they were when they lost their virginity. (The median age was 18 for both men and women in the study.)

The researchers sorted through all that data to find associations between specific DNA variants and the age at first sex, or AFS. Thirty-three of the variants were found in both men and women (though sometimes to differing degrees); four were seen in men only, and one was unique to women.

To see if their findings were just a fluke, they tested those same genetic variants in two other large groups -- Americans in the Women's Genome Health Study and Icelanders working with scientists at DeCode Genetics. (Although these people hadn't said how old they were when they first had sex, they did say how old they were when their first child was born, and the two traits have a strong genetic correlation.) Sure enough, the analysis confirmed all 38 variants, according to the study.

The researchers also noted that DNA's influence on the age at which someone loses their virginity has remained stable -- with heritability explaining about 26% to 28% of the variation -- even as cultural influences have caused people to start having sex at younger and younger ages.

"We show that a substantial proportion of variation in AFS is due to genetic factors, which likely act through a variety of biological mechanisms," the study authors concluded.

Others were more skeptical about the results. The fact that the study turned up so many variants related to age at first sex was a red flag for Alicia Smith, who investigates the genetic roots of psychiatric disorders at Emory University in Atlanta.

"In many cases, this indicates that the statistical model used to test the association doesn't fit the data and that there are false positives in the results," said Smith, who wasn't involved in the research.

Though the report focuses on the role of genetics, she said the findings also suggest this role is rather limited. The study “supports the idea that the age at which a man or woman first has sex is overwhelmingly due to non-genetic factors, such as social or environmental context,” she said.

But understanding the genetic factors is important, the study authors explained, because when DNA predicted an earlier sexual debut, people also had a few strikes against them. For instance, the researchers found that people with these variants were 26% less likely to qualify for college admission and 33% more likely to start smoking.

Knowing this might help researchers identify teens who could benefit most from programs aimed at promoting healthy behaviors, the study authors said.

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

Six weeks of sofosbuvir/ledipasvir is enough to cure acute hepatitis C in HIV-negative people

Liz Highleyman, aidsmap | 4.18

A regimen of sofosbuvir/ledipasvir (Harvoni) taken for six weeks cured all patients with genotype 1 acute hepatitis C virus (HCV) infection, including those with high viral loads, according to findings from a German study presented on Saturday at the 2016 International Liver Congress in Barcelona. The researchers said treating hepatitis C early with a short regimen would improve symptoms sooner, prevent HCV transmission and cost less than treatment initiated during chronic infection.

Studies done in the interferon era showed that treating people in the acute phase of HCV infection led to higher response rates and required a shorter duration than treatment of chronic infection. But because interferon-based therapy is poorly tolerated, many preferred to wait to see if the immune system would naturally clear HCV, which happens approximately 25% of the time.

The advent of interferon-free direct-acting antiviral (DAA) therapy has made chronic hepatitis C treatment shorter, better tolerated and more effective, leading experts to expect the same may be true for acute HCV infection. Yet there are currently no DAA regimens approved specifically for the treatment of acute hepatitis C, with current guidelines recommending the same options as used for chronic infection.

Katja Deterding and Heiner Wedemeyer of Hannover Medical School and fellow investigators with the German HepNet Acute HCV IV Study evaluated the safety and efficacy of sofosbuvir/ledipasvir for people with acute hepatitis C mono-infection. Dr Deterding presented the findings at a late-breaker session and Prof. Wedemeyer gave an overview during a press briefing.

This is the latest in a series of HepNet investigator-initiated acute hepatitis C studies. The others looked at interferon-based regimens taken for six months and saw sustained response rates ranging from 90 to 98%.

The prospective pilot study enrolled 20 participants at 10 centres in Germany between November 2014 and October 2015. Most (60%) were men and the mean age was 46 years. People with HIV co-infection were not included.

Acute HCV infection was defined as having known or suspected exposure to HCV within the prior four months, documented seroconversion from HCV antibody negative to positive, or an alanine aminotransferase (ALT) liver enzyme level more than 10 times the upper limit of normal – an indicator of acute liver inflammation.

The most commonly reported risk factors for HCV infection were sexual transmission (11 people or 55%) and medical procedures or needlestick injuries (five patients or 25%); only one reported injection drug use. Five of the suspected sexual transmissions were among men who have sex with men, with the remainder among heterosexual men and women. Although outbreaks of sexually transmitted HCV have been seen among HIV-positive gay men, heterosexual transmission is thought to be rare and HIV-negative gay men have HCV infection rates similar to those of the general population.

Eleven people had harder-to-treat HCV genotype 1a, while nine had 1b. Pre-treatment HCV viral load ranged from 3.3 to 6.7 log₁₀ IU/ml. The mean ALT level was 463 IU/l and the mean bilirubin level was 24 mg/dl. But some patients had very high levels, Prof. Wedemeyer said; the highest ALT level was over 2700 IU/ml and some patients had such high bilirubin levels they had icterus or jaundice, with yellowing of the skin and eyes.

All study participants were treated with sofosbuvir/ledipasvir in a fixed-dose co-formulation (400/90mg), without ribavirin, for six weeks. The usual recommended duration of sofosbuvir/ledipasvir for chronic hepatitis C treatment is 12 weeks, though people with no prior treatment experience, no cirrhosis and low viral load can be treated for eight weeks.

Everyone completed the full course of treatment and all had sustained virological response, or continued undetectable HCV RNA at the end of a 12-week post-treatment follow-up period (SVR12).

The researchers looked at the relationship between baseline viral load and early virological response. People with higher viral loads suppressed HCV more slowly, but all were undetectable by the end of treatment. This raises the prospect that an even shorter treatment duration may be adequate for some people.

Along with viral suppression, the patients experienced rapid biochemical response, or sharp declines in liver enzymes and bilirubin, with ALT normalisation and normal bilirubin levels by the end of treatment.

Treatment was generally safe and well-tolerated. There was one unrelated serious adverse event and no-one discontinued treatment early due to side-effects. The most frequently reported adverse events were gastrointestinal symptoms (20%), fatigue (15%) and hair loss (15%).

"Short treatment of only six weeks was highly effective with an SVR12 rate of 100% in acute HCV genotype 1 mono-infected patients," the researchers concluded. "High baseline viral load was associated with a delayed virological response, which however did not lead to treatment failures."

After Dr Deterding's presentation, Prof. Jürgen Rockstroh of the University of Bonn pointed out that his group conducted a study of the same regimen for HIV-positive men with acute HCV co-infection. As he

reported at the recent Conference on Retroviruses and Opportunistic Infections, six weeks of therapy cured co-infected people with low HCV viral load, but there were three relapses among patients with high baseline HCV RNA levels. These, along with a case of reinfection and two people lost to follow-up, resulted in an SVR12 rate of just 77%.

Prof. Wedemeyer told [aidsmap.com](#) that unlike in Prof. Rockstroh's study, the HIV-negative patients with high viral load in the HepNet study "cleared more slowly but stayed cleared." While some experts are now saying people with HIV and HCV co-infection are no longer a 'special population' when it comes to hepatitis C, he suggested "there is still a difference", even if they have high CD4 counts and HIV suppression.

At both the press briefing and the late-breaker session, attendees brought up the issue of delaying treatment for acute HCV infection to see if spontaneous clearance will occur, as was common practice in the interferon era.

"I would recommend to start [during acute infection] due to the high SVR rate and rapid improvement of symptoms," Dr Deterding responded.

If treatment is delayed, "patients would be ill for months," which could interfere with employment and lead to stigma due to jaundice, Prof. Wedemeyer elaborated. It usually takes up to eight weeks for liver enzymes and bilirubin to normalise after acute infection, compared to just one week in this study.

Prof. Wedemeyer added that early treatment is also important for preventing HCV transmission, given that viral load is often high during the acute stage. Further, he noted, cutting treatment duration from 12 weeks during chronic infection to six weeks during acute infection would reduce the price by half, which "could be an enormous health cost savings."

Reference:

Deterding K et al. Six weeks of sofosbuvir/ledipasvir (SOF/LDV) are sufficient to treat acute hepatitis C virus genotype 1 mono-infection: the HepNet Acute HCV IV Study. International Liver Congress, Barcelona, abstract LB08, 2016.

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

It May Be Possible to Vaccinate for HIV and Hepatitis C Simultaneously

As reported by POZ | 4.13

A dual hepatitis C virus (HCV) and HIV vaccine showed that the attempt to protect against both viruses at the same time did not impair the immune response to either. Researchers conducted a Phase I study of 32 HIV- and HCV-negative participants and presented findings at the 51st International Liver Congress in Barcelona.

The participants were divided into three groups, each of which received two vaccine doses, one eight weeks after the other. One group received only an investigational HCV vaccine; the second group received only an investigational HIV vaccine; and the third group received both vaccines, administered at the same time.

Both the HIV and HCV vaccines induced an immune response in the body, as evidenced by the number of HIV- and HCV-specific T-cells detected in blood samples. The second vaccine shot was associated with a subsequent increase in such immune responses.

The researchers found that giving both the HIV and HCV vaccines at the same time did not impair the intensity or the breadth of the immune response to either virus, when compared with giving a vaccine for just one virus.

The vaccines, which were administered through intramuscular injections, were well tolerated.

To read a press release about the study, [click here](#).

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

HIV Charity Triggers NHS U-Turn Over HIV Prevention Drug

Patrick Strudwick, BuzzFeed News | 4.19

The NHS in England is to reconsider its controversial decision not to provide the drug that prevents HIV, BuzzFeed News can reveal.

Faced with the threat of legal action by one of Britain's leading HIV charities, NHS England's lawyers have said a dedicated committee will meet next month to look again at the pronouncement.

The rethink represents a major victory for the National AIDS Trust (NAT), which sent NHS England a 17-page legal letter last week that laid out a string of reasons why the decision not to provide the drug was legally flawed.

Late on Monday – a week after NAT's letter was sent – NHS England's lawyers wrote to the charity to say their client would re-examine its position in light of the intervention.

NHS England's Specialised Services Committee will now meet in late May to consider whether the basis for the original decision was sound.

"We're delighted," Deborah Gold, the chief executive of NAT, told BuzzFeed News. "We're particularly delighted that when NHS England saw the strength of our legal case it made them rethink their position. But it's really important that when they do that reconsideration that it's a genuine, fair reassessment based on all of the facts, with an open mind."

NAT will be responding in writing to NHS England's lawyers to see if the review in May can be brought forward, Gold said.

The drug in question, Truvada, has been found to be highly effective, reducing the risk of infection by 86%. It is already available in the US, France, Canada, Kenya, and Israel, and when used in this prevention regime, is referred to as PrEP (pre-exposure prophylaxis).

On 21 March NHS England announced that just 500 gay men would be given the drug. The decision sparked anger and dismay among the medical community, the HIV charity sector, and sexual health

campaigners, as it abandoned a widely anticipated public consultation into PrEP that would have ticked one of the last boxes in an 18-month process for the NHS to commission the drug.

Had this route been followed, the final referral to the NHS England Board – which makes the ultimate decision – was expected to have been made in June.

The reason given by NHS England for shelving this process was that it is not responsible for HIV prevention, only HIV medication, and that local authorities were instead responsible for providing PrEP. This too was roundly criticised as many HIV experts highlighted that the NHS already provides the drug to people who have recently been exposed to the virus, as part of an intervention known as PEP (post-exposure prophylaxis).

Meanwhile, local authorities denied it was their responsibility and pointed out that they had no budget to fund the medication. The Department of Health then admitted to BuzzFeed News that it did not know whose responsibility it was.

Documents unearthed by BuzzFeed News also showed an apparent contradiction between NHS England's position last year and its decision last month.

The legal letter sent from NAT to NHS England highlighted a wide range of areas in which the decision last month was open to legal challenge.

These included: that NHS England had until March conveyed to interested parties that it was responsible for commissioning PrEP; that the decision on 21 March was made with "no prior warning or consultation"; that the "rationale for this sudden change of position" was not explained; that NHS England had misinterpreted the law and does in fact have a legal duty to commission drugs in this field. And finally, that by not doing so, NHS England could be seen to be contravening the Equality Act of 2010, due to the minorities who are most at risk of HIV infection.

Monday's letter from NHS England's lawyers outlined the process moving forward. The meeting by the Specialised Services Committee next month will re-examine whether NHS England is in fact responsible for commissioning PrEP and whether it has the power to fund it. If the committee decides it does have the duty and authority, it will refer the ultimate decision to the Clinical Priorities Advisory Group (CPAG).

Because of the delay caused by the derailment of the original process, this referral will happen whether or not there is time for a public consultation. It is also possible, the letter said, that the CPAG meeting might be postponed a little in order to ensure PrEP is given proper consideration.

"We will still be watching and willing to instigate legal action at a later date if we aren't successful in their reconsideration in May," Gold told BuzzFeed News. "We're not walking away from this, but our preference is to solve it without having to take legal action."

Last week, just before NAT's letter was sent out, the charity met with NHS England to discuss its concerns. "At that point they didn't seem willing to reconsider," said Gold. "But after getting the letter from our solicitors I think it was then they realised what we've been saying all along – which is they've made an error in the law."

Gold said the wider background to the announcement, with the press exposing issues surrounding the decision, and a backlash from communities most affected by the virus, will have played a part in triggering NHS England's U-turn.

"They've very sensitive to this," she said. Ultimately, however, the charity remains focused on the final outcome. "I hope this reconsideration gives NHS England the opportunity to take a step back and make a better decision."

If HIV charities like NAT are successful and NHS England decides to fund PrEP, Gold said, people "currently at high risk of HIV could have this extraordinary new treatment that could be a game-changer for HIV. It's the most important thing that has happened in HIV prevention since the discovery of antiretrovirals. It could therefore turn the tide on the HIV epidemic in a way that nothing else has."

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

Doctors fear spread of 'super-gonorrhoea' across Britain

Drug-resistant strain of sexually transmitted superbug at risk of becoming untreatable, say health experts

Press Association, as reported by The Guardian | 4.17

A highly drug-resistant type of "super-gonorrhoea" is spreading across the country, with senior medics warning it may become untreatable.

A powerful strain of the sexually transmitted superbug first seen in the north of England has been found in the West Midlands and the south-east, Public Health England (PHE) said.

The strain is highly resistant to the antibiotic azithromycin, which means medics are relying on a second drug, ceftriaxone, to treat it. But there are no other effective drugs to tackle the strain, raising the prospect of it becoming untreatable if it builds further resistance.

PHE urged people to use condoms with new or casual partners to cut the risk of catching the disease. If untreated, gonorrhoea can result in severe complications and in rare cases lead to infertility or septicaemia.

Dr Gwenda Hughes, the head of PHE's sexually transmitted infections (STI) section, said: "Fortunately, the current outbreak strain can still be treated with ceftriaxone. Nonetheless, we know that the bacterium that causes gonorrhoea can rapidly develop resistance to other antibiotics that are used for treatment, so we cannot afford to be complacent.

"If strains of gonorrhoea emerge that are resistant to both azithromycin and ceftriaxone treatment options would be limited as there is currently no new antibiotic available to treat the infection."

PHE said on Sunday there had been 34 confirmed cases since November 2014. Since September 2015, 11 cases have been confirmed in the West Midlands and in the south of England, five of them in London.

At least 16 cases were first detected in northern England, including 12 in Leeds, where the mutated strand was first recorded, PHE said in September.

The strain, which is resistant to first-line antibiotic azithromycin, spread from Leeds to patients in Macclesfield, Oldham and Scunthorpe. Cases have been found in heterosexual men and women, and men who sleep with men (MSMs), PHE said.

The British Association for Sexual Health and HIV issued an alert to clinicians urging them to follow up cases of high-level drug-resistant gonorrhoea and trace their sexual partners.

Its president, Dr Elizabeth Carlin, told the BBC: "The spread of high-level azithromycin-resistant gonorrhoea is a huge concern and it is essential that every effort is made to contain further spread. Failure to respond appropriately will jeopardise our ability to treat gonorrhoea effectively and will lead to poorer health outcomes for individuals and society as a whole."

There were almost 35,000 cases of gonorrhoea reported in England in 2014 and it is the second most common bacterial sexually transmitted infection in the UK after chlamydia, with the majority of cases affecting people under the age of 25.

Infected patients may experience discharge or pain while urinating, but about 10% of men and almost half of women do not suffer any symptoms.

Concerns have been growing over "untreatable" strains of gonorrhoea, and in 2012, the European Centre for Disease Prevention and Control warned that drug-resistant forms of the STI were spreading across Europe.

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

Scientific Papers/Conference Abstracts

Symptoms, Side Effects and Adherence in the iPrEx Open-Label Extension

Glidden DV, Amico KR, Liu AY, et al. *Clinical Infectious Diseases* 2016;62(9):1172-1177

Background.

Blinded clinical trials have reported a modest and transient "start-up syndrome" with initiation of tenofovir-based pre-exposure prophylaxis (PrEP). We evaluate this phenomenon and its effect on adherence in an open-label PrEP study.

Methods.

In the iPrEx open-label extension (OLE) study, an 18-month open-label, multi-site PrEP cohort taking daily oral co-formulated tenofovir/emtricitabine, we examined the prevalence and duration of PrEP-associated symptoms and their effect on adherence, assessed by drug levels in dried blood spots tested monthly for the first 3 months.

Results.

Symptom reports peaked within the first month, with 39% reporting potentially PrEP-related symptoms compared to 22% at baseline. Symptoms largely resolved to pre-PrEP levels by 3 months.

Symptoms varied substantially in frequency by study site (range in 1-month symptoms: 11% to 70%). Nongastrointestinal (GI) symptoms were not associated with adherence (odds ratio [OR] = 1.2, 95% confidence interval [CI], .4–3.7); however, GI-associated symptoms in the first 4 weeks were inversely associated with adherence at 4 weeks (OR = 0.47, 95% CI, .23–.96). Reports of GI symptoms were associated with 7% (95% CI, 4%–11%) of suboptimal adherence in this cohort.

Conclusions.

PrEP-associated symptoms in the open-label setting occur in a minority of users and largely resolve within 3 months. GI symptoms are associated with a modest reduction in PrEP adherence, but good adherence is possible even in the presence of frequent symptom reports.

View the paper online: [Abstract](#)

A Pilot Trial of a Sexual Health Counseling Intervention for HIV-Positive Gay and Bisexual Men Who Report Anal Sex without Condoms

Hart TA, Stratton N, Coleman TA, et al. *PLoS ONE* 2016; <http://dx.doi.org/10.1371/journal.pone.0152762>

Background

Even in the presence of promising biomedical treatment as prevention, HIV incidence among men who have sex with men has not always decreased. Counseling interventions, therefore, continue to play an important role in reducing HIV sexual transmission behaviors among gay and bisexual men and other men who have sex with men. The present study evaluated effects of a small-group counseling intervention on psychosocial outcomes and HIV sexual risk behavior.

Method

HIV-positive (HIV+) peer counselors administered seven 2-hour counseling sessions to groups of 5 to 8 HIV+ gay and bisexual men. The intervention employed information provision, motivational interviewing, and behavioral skills building to reduce sexual transmission risk behaviors.

Results

There was a significant reduction in condomless anal sex (CAS) with HIV-negative and unknown HIV-status partners, from 50.0% at baseline to 28.9% of the sample at 3-month follow-up. Findings were robust even when controlling for whether the participant had an undetectable viral load at baseline. Significant reductions were also found in the two secondary psychosocial outcomes, loneliness and sexual compulsivity.

Conclusions

The findings provide preliminary evidence that this intervention may offer an efficient way of concurrently reducing CAS and mental health problems, such as sexual compulsivity and loneliness, for HIV+ gay and bisexual men.

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

Rationale and Safety Assessment of a Novel Intravaginal Drug-Delivery System with Sustained DL-Lactic Acid Release, Intended for Long-Term Protection of the Vaginal Microbiome

Verstraelen H, Vervaet C, Remon JP. *PLoS ONE* 2016; <http://dx.doi.org/10.1371/journal.pone.0153441>

Abstract:

Bacterial vaginosis is a prevalent state of dysbiosis of the vaginal microbiota with wide-ranging impact on human reproductive health. Based on recent insights in community ecology of the vaginal microbiome, we hypothesize that sustained vaginal DL-lactic acid enrichment will enhance the recruitment of lactobacilli, while counteracting bacterial vaginosis-associated bacteria. We therefore aimed to develop an intravaginal device that would be easy to insert and remove, while providing sustained DL-lactic acid release into the vaginal lumen. The final prototype selected is a vaginal ring matrix system consisting of a mixture of ethylene vinyl acetate and methacrylic acid-methyl methacrylate copolymer loaded with 150 mg DL-lactic acid with an L/D-lactic acid ratio of 1:1. Preclinical safety assessment was performed by use of the Slug Mucosal Irritation test, a non-vertebrate assay to evaluate vaginal mucosal irritation, which revealed no irritation. Clinical safety was evaluated in a phase I trial with six healthy nulliparous premenopausal volunteering women, with the investigational drug left in place for 7 days. Colposcopic monitoring according to the WHO/CONRAD guidelines for the evaluation of vaginal products, revealed no visible cervicovaginal mucosal changes. No adverse events related to the investigational product occurred. Total release from the intravaginal ring over 7 days was estimated through high performance liquid chromatography at 37.1 (standard deviation 0.9) mg DL-lactic acid. Semisolid lactic acid formulations have been studied to a limited extent in the past and typically consist of a large volume of excipients and very high doses of lactic acid, which is of major concern to mucosal safety. We have documented the feasibility of enriching the vaginal environment with pure DL-lactic acid with a prototype intravaginal ring. Though the efficacy of this platform remains to be established possibly requiring further development, this approach may offer a novel avenue to modulate and protect the vaginal microbiota.

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

A Randomized Controlled Trial of POWER: An Internet-Based HIV Prevention Intervention for Black Bisexual Men

Fernandez MI, Hosek SG, Hotton AL, et al. *AIDS and Behavior* 2016; [Epub ahead of print]

Abstract:

POWER is a theory-based, on-line HIV prevention intervention developed specifically for Black men who have sex with men and women (BMSMW), an understudied group significantly impacted by HIV. To test its efficacy, we recruited 224 BMSMW using chain referral methods and randomly assigned 108 to POWER and 103 to a health information comparison condition. Three months after the intervention, participants assigned to POWER had lower odds of reporting any condomless vaginal or condomless anal intercourse (CVAI) compared to those in the comparison group (aOR = 0.49; 95 % CI 0.25–0.98; $p = 0.044$). The intervention was associated with significantly lower odds of condomless anal intercourse with male partners (aOR = 0.55; 95 % CI 0.34–0.91; $p = 0.020$) but not with female partners and serodiscordant sex with male partners but not with female partners. Future studies are needed to replicate these findings in larger and more diverse samples of BMSMW and to understand the underlying mechanisms through which intervention efficacy was achieved.

View the paper online: [Abstract](#)

Cost considerations in the current ARV era.

Eaton EF, Tamhane A, Saag M, et al. *AIDS* 2016; [Epub ahead of print]

Background:

U.S. National guidelines call for cost-conscious practices including the selection of antiretroviral therapy (ART).

Objective:

To analyze the relative cost-effectiveness of contemporary ART in real-world clinical settings.

Design:

Observational cohort study.

Methods:

Retrospective follow-up study of treatment naive PLWH initiating ARV between Jan '07 and Dec '12 at an academically-affiliated HIV clinic was conducted. Analysis was restricted to patients with the 5 most commonly prescribed regimens (N = 491). Patients were followed until Dec '14 to determine the durability of the initial regimen prescribed; median durations were calculated using Kaplan-Meier survival analyses. The average 340b price of the ARV 30-day supply was used for cost. Sensitivity analyses were performed adjusting for missing data and pricing indices and using mean durability (+/- 1 SD).

Results:

Initial regimens contained Emtricitabine and Tenofovir, along with a 3rd drug. Median durability was shortest for ritonavir-boosted Atazanavir (31.9 mos) and longest for ritonavir-boosted Darunavir and Raltegravir (both 47.8 mos). All regimens were dominated, meaning less durable and more costly, relative to Efavirenz (\$710.64/month) and Raltegravir-based regimens (\$1075.03/month). These findings were reproduced in sensitivity analysis, although Rilpivirine became a valuable option in some scenarios. Relative to the Efavirenz-based regimen, Raltegravir had an incremental cost of \$47 per month of additional therapy.

Conclusions:

In this sample, Raltegravir and Efavirenz-based regimens are the most cost-effective options for treatment naive patients. Sensitivity analyses suggest Rilpivirine is a reasonable choice in limited scenarios. These findings are relevant given changes in recommended regimens for treatment naive persons, which include Raltegravir and Darunavir but exclude Efavirenz and Rilpivirine-based regimens.

Summary:

Of five commonly prescribed regimens for treatment-naive HIV patients in one clinic (2007-2012), Emtricitabine and Tenofovir with Efavirenz and Raltegravir were the only consistently cost-effective options; the Rilpivirine-based regimen was valuable in limited scenarios. Further data on the comparative effectiveness of Efavirenz and Rilpivirine are needed before they are abandoned.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

REGISTER for the 2016 National Latino HIV and Hepatitis C Conference

Registration is now open for the **2016 National Latino HIV and Hepatitis C Conference to be held June 6-8 in South Padre Island, Texas**. AIDS United is honored to be supporting the efforts of the Valley AIDS Council, along with their conference partners to bring you this ground-breaking event.

This is the first national conference in the U.S. focusing exclusively on how HIV and Hepatitis C are impacting the Latino community and the co-/factors that contribute toward Latino's vulnerability for these diseases. Attending this conference will bring you together with national leaders and over 250 health care professionals to discuss the treatment and care needs of Latino communities impacted by HIV and Hepatitis C.

If you work with Latino patients and populations, this conference will instill in you innovative concepts, best practices, and new information on how to best serve our Latino patients and communities. To learn more and to register, visit the [conference website](#).

Should you have any questions, feel free to contact the conference coordinators at 956-245-1603 or at ruben@latinosandhiv.org

STD Awareness Month: CDC Encourages Everyone to Talk, Test, and Treat

Gail Bolan, Blog.aids.gov | 4.20

A special note to the public from Dr. Gail Bolan, Director, Division of STD Prevention, CDC, this STD Awareness Month.

April is [STD Awareness Month](#), which gives us the opportunity to talk about sexual health in an inclusive way that speaks to individuals from all walks of life. Sex is a part of most of our lives—but sexually transmitted diseases (STDs) do **not** have to be one of the “facts of life.”

Here is the current situation in the United States:

- **About 20 million new sexually transmitted infections (STIs) are diagnosed each year**, half are among youth ages 15-24; young people and gay, bisexual and other men who have sex with men (MSM) continue to be disproportionately affected by these common STDs.
- **More than 110 million new and existing STIs have been diagnosed among men and women overall.**
- **An estimated 44,073 people were diagnosed with HIV in 2014**; an estimated 1.2 million are living with the disease.
- For the first time in more than a decade, **rates of chlamydia, gonorrhea, and syphilis all increased** in the same year.
- **The number of [babies born with syphilis](#) spiked** in recent years, a trend paralleling national increases of early syphilis in women.

- **Reported cases of [syphilis that has spread to the eye](#)** have also increased among men and women; however, the majority of these cases have been among MSM living with HIV.

The data and health outcomes are concerning, yes, but to protect yourself this [STD Awareness Month](#), and all year long, hear and remember these words—*Talk. Test. Treat.*

Talk. Talk openly and honestly with your partner(s) and with your healthcare provider about your sexual practices, history, and STDs. Talk with your partner *before* having sex. Check out available [resources](#) to help you start the conversation. Talk with your healthcare provider about your sex life. If they don't bring it up, take charge of your health and ask what tests for STDs and HIV you should be getting and how often.

Test. Get yourself tested. It's the only way to know for sure if you have an STD. Check out this [screening recommendations page](#) to see what's recommended routinely. Even if you are pregnant you are still at risk and screening recommendations apply. Visit [this website](#) to find a place to be tested near you.

Treat. If you test positive for an STD, work with your doctor to get the medically correct treatment, ASAP. Some STDs can be cured. HIV and other STDs aren't curable, but they are treatable. Your doctor can talk with you about which medicines are right for you.

Life can be complicated, but good sexual health doesn't have to be. Just remember these three things to protect yourself—*Talk. Test. Treat.* For more information and resources, please visit our [STD Awareness Month website](#).

More information is available [online](#), or follow [@CDCSTD](#)  on Twitter and [CDC STD](#)  on Facebook.

For more information: [Click here](#)

CDC Releases New Resource Guide for Perinatal Quality Collaboratives

Developing and Sustaining Perinatal Quality Collaboratives
A Resource Guide for States

Perinatal quality collaboratives, or PQCs, are networks of perinatal care providers and public health professionals working in multidisciplinary teams to improve measurable outcomes for women and newborns through continuous quality improvement. The Centers for Disease Control and Prevention (CDC) recognizes the value that PQCs can bring to improving perinatal health and worked with experts to develop a resource guide to help develop and advance the work of state PQCs. Topics in the guide include starting a statewide collaborative, launching initiatives, data and measurement, sustainability, and more.

Download PDF: [Developing and Sustaining Perinatal Quality Collaboratives A Resource Guide for States](#)

Early Registration Deadline April 28 – 21st International AIDS Conference

The [21st International AIDS Conference \(AIDS 2016\)](#) will offer a best-in-class programme with over 500 conference activities and sessions driven by top science and research discoveries. Here is a first glimpse

of some of the scientific highlights:

HIV Vaccine & Functional Cure: Continuing Momentum

- Cutting-edge research on gene-editing to help eradicate HIV
- Novel discoveries on latently infected HIV cells, including how frequently cells are reactivated and how long they survive
- New approaches to reduce the HIV viral reservoir and restore CD8+ T-cell function

Findings from Prevention Interventions and Trials

- State of the HIV epidemic among women, including a 15-year trend analysis of the HIV gender gap between adolescent girls and boys in sub-Saharan Africa, as well as insights into HIV vulnerability of young women in inter-generational relationships
- Qualitative analyses of landmark HIV prevention trials for women shedding new light on adherence
- Insights on men who have sex with men (MSM) prevention issues, including new data on risk associated to online sex-seeking behaviours as well as mental health issues for MSM
- Cost-effectiveness of harm reduction interventions for people who inject drugs, as well as innovative approaches to increase their adherence to HIV treatment

Implementation and Progress

- Analysis of countries' capacities to report diagnosis, treatment and viral suppression data, and implications for tracking global progress towards achieving the 90-90-90 treatment goals
- Progress and challenges in scaling up viral load testing in resource-limited settings
- Optimal treatment strategies from high-burden regions, with lessons learned in reaching targets across the continuum of care
- Analysis of year-to-year and long-term trends in HIV research funding, and implications for future funding needs

PrEP: Fulfilling its Current & Future Potential

- Innovative methods to increase PrEP uptake in clinics, through community-based service delivery and at home
- Latest information on next generation PrEP options, including long-acting injectables
- New data to guide PrEP implementation, including cost-effectiveness analyses across low-, middle- and high-income countries
- Key insights from several PrEP open-label extension and demonstration studies

HIV Co-infections & Co-morbidities: Overcoming Remaining Challenges

- Advances in viral hepatitis and HIV co-infection treatment
- Innovative strategies to reduce HIV and tuberculosis (TB) co-infection, including prevention of TB drug resistance

New data on the impact of co-morbidities – such as cancers, and cardiovascular, renal, and bone diseases

For more information and to register: [Click here](#)

WEBINAR: Tuesday, April 26, 2016, Zika Virus Outbreak: CDC Update for IHS Clinicians

DATE: April 26

TIME: 10:00 – 11:00 AM PST

This one hour webinar will be presented by:

Dr. Maleeka Glover, ScD, MPH, Dr. Susan Hills MD, MPH, and Dr. Dana Meaney-Delman, MD, MPH, FACOG

Target Audience

Educators, Health & Educational Administrators, Nurses, Nurse Practitioners, Counselors, Pharmacists, Pharmacy Technicians, Psychologists, Dentists, Physicians, Physicians Assistants, Social Workers, Allied Health Professionals, Psychiatrists.

Webinar Description and Objectives

As we learn more about how the Zika virus is transmitted and impacts health, healthcare providers need clear information to guide the counseling and management of patients concerned about or potentially exposed to Zika virus as well as how to prevent its transmission to developing fetuses and sexual partners. Please join us for this IHS Clinical Rounds special session on the emerging Zika virus epidemic in the Americas as we partner with experts from the Centers for Disease Control and Prevention (CDC) to present the latest information on:

- Zika virus 101: basic epidemiology, Zika virus risk mitigation, and prevention measures
- Laboratory testing for Zika virus
- Zika virus and Guillain-Barre Syndrome
- Zika virus infection and pregnancy
- CDC guidance for pregnant women
- Overview of the U.S. Zika Pregnancy Registry

At the end of this presentation, participants will be able to:

1. Enhance awareness among IHS clinical providers and staff of the ongoing Zika virus outbreak in the Americas and complications associated with illness.
2. Identify patients at higher risk for Zika virus infection to facilitate appropriate screening and management in accordance with current recommendations.
3. Describe current CDC guidelines for clinicians caring for women of reproductive age and their partners with possible Zika exposure.

Registration/Connection Information

There is no fee to participate in this webinar. The session is open and registration is not required. Use the link/instructions below on the day of the presentation to be connected.

1. Go to: <http://ihs.adobeconnect.com/ihsrounds>
2. Select the “Enter as a Guest” option.
3. Input your name (first and last) in the Name box.
4. The passcode is: **rounds**
5. Press the “Enter Room Button”

Adobe Connect First Time Users

The IHS uses Adobe Connect for online meetings. If you have never attended an Adobe Connect meeting before, please test your connection before the session.

http://ihs.adobeconnect.com/common/help/en/support/meeting_test.htm

Hardware Requirements

You must have a computer with broadband Internet access. For the best experience viewing the videos, use Internet Explorer 7 or greater and Flash 8 player. Click on the "Flash" icon to install the player, if necessary. If you have any trouble viewing the video trainings, contact us at ALB_AO.esupport@ihs.gov for alternate viewing options. If you have trouble viewing this training on-line, check your system to make sure you have the appropriate hardware and software. If you need help or have any questions, please send an email to ALB_AO.esupport@ihs.gov.

Note: Before you begin the training, you can review the IHS Privacy Policy (http://www.ihs.gov/privacy_policy.asp).

Recording

All sessions are recorded and can be accessed at:

<https://www.ihs.gov/telebehavioral/index.cfm/seminararchive/>.

WEBINAR: News and expert analysis from the 2016 International Liver Congress

DATE: April 25

TIME: 8:00 – 9:00 AM EST

Receive an update on key research findings and guidance presented at the 2016 International Liver Congress and their implications for treatment, prevention, public health policy and advocacy from experts in viral hepatitis.

Featuring:

- Dr Sanjay Bhagani, Consultant in Infectious Diseases, Royal Free Foundation NHS Trust, London
- Professor Jeffrey Lazarus, University of Copenhagen, Editor in Chief, *Hepatology, Medicine and Policy*
- Raquel Peck, Chief Executive Officer, World Hepatitis Alliance

Registration

The webinar will take place on Monday 25 April 1-2pm UK / 2-3pm CET / 8-9am EST

[Click here to register to take part.](#)

Job/Internship Postings

Supervising Communicable Disease Investigator Vacancy - San Diego County

Organization: San Diego County

Location: San Diego, CA

Salary: \$57,969.60 - \$71,260.80 Annually

Public Health Services has an immediate opening for Supervising Communicable Disease Investigator. Incumbent will be responsible for planning, supervising, and coordinating the work of Communicable Disease Investigators and other staff members engaged in communicable disease investigations, clinical counseling services.

For a complete job description including essential functions, required certifications, working conditions, essential physical characteristics, etc., please click [here](#).

REQUIRED EDUCATION AND/OR EXPERIENCE

1. A bachelor's degree from an accredited U.S. college or university, or certified foreign studies equivalency in a behavioral, social, natural science, or a closely related field; AND, at least three (3) years of investigative experience in enforcement of communicable disease laws, rules, and regulations in a position comparable to Communicable Disease Investigator in the County of San Diego; OR,
2. Any combination of higher education and investigative experience in the enforcement of communicable disease laws, rules, and regulations in a position comparable to Communicable Disease Investigator in the County of San Diego, totaling seven (7) years.

NOTE: A State of California Phlebotomy License is required within six (6) months of employment.

EVALUATION

Qualified applicants will be placed on a twelve (12) month employment list based on scores received during the evaluation of information contained in their employment and supplemental application. Please ensure that all information is complete and accurate as the responses you provide on the supplemental application form will be reviewed using automated evaluation system. If you are successful in the initial screening process your application will be reviewed individually to confirm that the information you provided is accurate and qualifying.

NOTES

Reasonable accommodation may be made to enable an individual with qualified disabilities to perform the essential functions of a job, on a case-by-case basis.

The County of San Diego and its employees embrace the Live Well San Diego vision: A region that is Building Better Health, Living Safely and Thriving. Click here for more information www.livewellsd.org.

Under California Government Code Sections 3100 - 3109, public employees are designated as disaster service workers. The term "public employees" includes all persons employed by the state or any county, city, state agency, or public district. Disaster service workers are required to participate in such disaster service activities as may be assigned to them by their employer or by law.

For more information: [Click here](#)

Aaron Kavanaugh
Office of Policy, Planning, and Communications
STD Control Branch, California Department of Public Health

850 Marina Bay Parkway, Building P, 2nd Floor
Richmond, CA 94804

Tel: 510-231-1773
Fax: 510-620-3180
Web: std.ca.gov

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

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