

[STD Update] FYI 3-1: Long acting PrEP injection tolerable and acceptable for male volunteers, People with HIV overestimate their chance of infecting someone, CDC guidelines on STI testing for PrEP patients may miss cases, 4 papers, 1 webinar, more.

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National Stories

Long-acting PrEP injection tolerable and acceptable for male volunteers, but dose adjustment needed

Gus Cairns, aidsmap | 2.25

The Conference on Retroviruses and Opportunistic Infections (CROI 2016) heard results yesterday from the first phase 2 (safety, acceptability and dose-finding) study of a long-lasting, injectable formulation of the integrase-inhibitor drug cabotegravir for use as pre-exposure prophylaxis (PrEP) in HIV-negative people.

The previous day the conference had heard a presentation of a study of the same injectable drug, plus another injectable drug, rilpivirine, used as treatment for people with HIV – see this report.

In the cabotegravir PrEP study, dubbed the ECLAIR study, a couple of surprises awaited the researchers. Firstly, the rate of absorption of the drug into the body was faster than expected, meaning that an injection will probably have to be given every eight weeks, instead of every 12 weeks as hoped. Secondly, the duration and severity of pain and other effects of the injections were greater than expected; however few people dropped out of the study because of them, and three-quarters of participants said they would be happy to continue taking cabotegravir injections as PrEP should it become available.

The ECLAIR study lasted for 81 weeks altogether: presenter Martin Markowitz did not present final results as the final, follow-up phase has just finished. For the first four weeks, subjects took a daily oral cabotegravir pill (or a placebo pill – one in five subjects took the placebo). This oral phase was intended as a precaution to weed out any subjects who have unusual adverse reactions to cabotegravir – since one of the problems of an injectable formulation is that it cannot be suddenly stopped.

At weeks five, 17 and 29, three doses of injectable cabotegravir were given. These consisted of 800 milligrams of cabotegravir given as two two-millilitre injections, one in each buttock, or of saline as placebo. The ‘injection phase’ was defined as lasting till week 41, 12 weeks after the last injection. There was then a follow-up phase of 40 weeks till week 81; not all the data has yet been collected from this phase.

The study population consisted of men aged between 18 and 64 defined as being at low risk of HIV infection (as this is largely a safety, not a prevention trial). Their average age was 30.5 years, 57% were white and 32% African-American, and roughly 80% were gay and 20% heterosexual.

One hundred and twenty-six men entered the trial, 105 allocated to cabotegravir and 21 to placebo.

During the first four weeks on the oral pill, eleven people withdrew from the study who were taking cabotegravir, and one taking placebo. During the injection period, a further seven people, all on cabotegravir, withdrew, four of them due to intolerance of the injections. The fact that more people withdrew in the oral phase was attributed by Dr Markowitz as being due to caution on the part of the investigators at ensuring that no-one who showed any possibility of side-effects went forward to the injection phase. In particular, three subjects in the oral phase saw an increase in levels of creatine phosphokinase, an enzyme that indicates injury to muscle tissue, and although these were almost certainly not drug-related, they were withdrawn from receiving an intramuscular injection as a precaution.

In the injection phase, the primary adverse event was injection site reactions: these were almost universal in the subjects receiving cabotegravir, with 93% reporting them, and 57% receiving placebo. Injection site reactions largely consisted of pain in the muscle at the injection site. Pain was generally mild in placebo recipients but in cabotegravir recipients 37% defined it as ‘moderate’ and 10% as ‘severe’ and lasting, on average, for 5.4 days. Other injection site reactions included itching, swelling and heat at the injection site. The only non-local side-effect was fever, experienced by 7% of men receiving cabotegravir.

Despite this, 62% of people on cabotegravir said they were satisfied with their study medication, and 74% said they would be happy to continue receiving it. In fact more people said they preferred the 12-weekly injection to having to take a daily tablet.

Drug level measurements of cabotegravir showed that it was absorbed by the body faster than expected. This meant that the peak level of drug in the bloodstream, just after the injection, was higher than expected, and the trough level, just before the next injection, was lower than expected.

A model had forecast that the peak level in blood would be three micrograms per millilitre (mcg/ml) when in fact the average level was 5-6 mcg/ml, and the average trough level would be 1 mcg/ml when in fact it was 0.3-0.6 mcg/ml. This is of concern since it is close to the IC90, the level of drug that cuts 90% of viral replication, and drug levels should be well above this to ensure efficacy. The proportion of trial subjects whose trough drug levels fell below the IC90 was 24% after the first injection, 31% after the second and 15% after the third.

Dr Markowitz said that the reason for the faster absorption was unknown but it would probably mean that cabotegravir PrEP would have to be given every two months rather than every three.

There were two cases of HIV infection in the study. One person receiving placebo tested HIV positive at week 23. The other had received cabotegravir, but tested positive at week 53, nearly six months after his last cabotegravir injection. At this point he still tested HIV-antibody negative but had a viral load of over three million copies/ml, so it must have been a very recent infection. He had no detectable cabotegravir in his bloodstream at this point.

Dr Markowitz concluded that these results indicated that cabotegravir injections were safe and, despite injection site reactions, relatively well-tolerated. A parallel trial is happening in women and when this has concluded the final decision will be taken about taking injectable cabotegravir PrEP forward into a fully-fledged effectiveness trial, where it would be compared with oral tenofovir/emtricitabine (Truvada).

Reference:

Markowitz M et al. *ÉCLAIR: phase 2a safety and PK study of cabotegravir LA in HIV-infected men*. Conference on Retroviruses and Opportunistic Infections, Boston, abstract 106.

[View the abstract on the conference website.](#)

[View a webcast of this session on the conference website.](#)

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

People with HIV considerably overestimate their chance of infecting someone

No relationship seen between a person's view of their infectiousness and their viral load

Gus Cairns, aidsmap | 2.24

Only a small proportion of HIV-positive people in a large US treatment study, ACTG A5257, regarded themselves as non-infectious after up to three years on antiretroviral therapy (ART), and a third of participants regarded their chance of infecting a partner as still "high", even though only 10% of participants actually had a detectable viral load, the Conference on Retroviruses and Opportunistic Infections (CROI 2016) heard yesterday.

The study showed that there was no correlation between a person's actual viral load and their belief about how infectious they were, Dr Raphael Landovitz of the University of California in Los Angeles told the conference.

ACTG A5257 was a large drug-comparison study in which 1809 participants were randomised to receive either raltegravir, boosted atazanavir or boosted darunavir, plus tenofovir/emtricitabine. The 96-week results were presented at the CROI 2014 conference. The trial enrolled participants between 2009 and 2011 and patients were asked about their infectiousness beliefs one, two and three years after starting ART, so this study includes responses up to 2014.

A quarter of the study population was women, the mean age was 37, and ethnicity was distributed quite evenly, with 34% white, 42% African-American and 22% Hispanic. The median viral load at baseline was 40,000 copies/ml, with 30% having a viral load over 100,000 copies/ml.

The participants were asked the question "How likely would you be to give someone HIV if you had unprotected sex with them today?"

They rated how infectious they thought they were on a visual analogue scale, from "not infectious at all" (zero) to "highly infectious" (100). They were then divided into four categories: those who thought they were not infectious, and those who thought their risk of infecting another person was "low" (score 1-33), "medium" (34-66) or "high" (67-100).

As the start of the study, 58% thought they were highly infectious, and 26% placed themselves in the "medium" category. This left 16% who thought – at this point inaccurately – that their risk of infecting another person was "low" (10%) or zero (6%).

After a year on ART, a higher proportion – just under one-third – thought their risk of infecting someone was low. But 38% still thought their infectiousness was high. The percentage who thought they were not infectious at all had increased slightly to 10%. (Incidentally, 8.1% of this 10% – just eight individuals – were actually mistaken in their belief at this point, did have a detectable viral load, and were, to at least some extent, infectious.)

This hardly changed at all in the subsequent two years. At week 96, when 90% of trial participants were in fact virally suppressed, 36% still thought they were highly infectious and 19% were in the "medium" category. The proportion who thought their chance of infecting others was low had gone up just one point to 33%, and the proportion who thought they were not infectious to 12%.

By week 144, after three years on ART, 34% still thought they were highly infectious and a majority (52%) thought they were highly or somewhat infectious. The "low" category had increased by two points to 35% and the non-infectious by two points to 14%.

In other words, after three years on largely suppressive antiretroviral therapy, the proportion who thought they were highly infectious had roughly halved and the proportion who believed they were not infectious had roughly doubled, but these figures in no way reflected the actual proportions who were infectious, and had no relationship with people's actual viral load.

At week 48, young people aged under 30 were somewhat more likely than average to regard their infectiousness as having fallen. Black people, people with lower educational attainment, and people who entered the study with a very low CD4 count were less likely.

Women and Hispanic people were more likely to put themselves in the "not infectious" category at week 48, and users of recreational drugs and those who at baseline had seen themselves as highly infectious were less likely.

The study team will now analyse the data further to find if people's beliefs about their infectiousness had any impact on their sexual risk behaviour and choices of partner.

Given that people's beliefs about their infectiousness, although changing somewhat after starting treatment, had little relationship to whether they were infectious, Dr Landovitz was asked whether patients were taking over-cautious messages from healthcare professionals to heart, or felt, due to HIV stigma, that they still had to profess a belief in their own infectiousness.

Dr Landovitz commented that ACTG A5257 spanned the period during which, in May 2011, the results were announced from the HPTN 052 study, which confirmed that people with HIV who were on ART were rarely infectious. This result appears to have had little impact on the ACTG A5257 participants. However the trial finished around the time that the even more persuasive PARTNER study, which found no transmissions from anyone with an undetectable viral load, announced its interim findings; Dr Landovitz commented that if this same sub-study was repeated today, people's beliefs about their infectiousness might be different.

Asked what message we should give to patients about viral load and infectiousness, he commented: "Don't give them a dumbed-down message and talk in absolutes. In my experience, people want nuanced information about their risk of infecting others and want to be able to make up their own minds."

Reference

Landovitz RJ et al. *Perception of infectiousness in HIV-infected persons after initiating ART: ACTG A5257*. Conference on Retroviruses and Opportunistic Infections, Boston, abstract #55, 2016.

[View the abstract on the conference website.](#)

[View a webcast of this session on the conference website.](#)

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

Maraviroc-containing regimens safe, tolerable when taken for HIV prevention

As reported by Medical News Today | 2.25

Maraviroc, an oral drug used to treat HIV infection, is safe and well-tolerated when taken daily as pre-exposure prophylaxis (PrEP) to prevent HIV infection by HIV-uninfected men who have sex with men (MSM) at increased risk for acquiring HIV. These findings from the Phase 2 HPTN 069/ACTG 5305 trial were presented today at the Conference on Retroviruses and Opportunistic Infections in Boston. The trial was sponsored by the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health, and conducted by the NIH-funded HIV Prevention Trials Network, in collaboration with the AIDS Clinical Trials Group.

A daily pill called Truvada containing the antiretroviral drugs tenofovir disoproxil fumarate (TDF) and emtricitabine currently is the only PrEP regimen approved by the Food and Drug Administration. TDF and emtricitabine interfere with viral replication after HIV has entered cells. Maraviroc blocks HIV from entering cells and concentrates in the rectum and genital tract.

In the study, 406 MSM in the United States and Puerto Rico were randomly assigned to take either once-daily maraviroc alone, maraviroc plus TDF, maraviroc plus emtricitabine, or TDF and emtricitabine. Investigators found that the maraviroc-containing regimens were as safe and well-tolerated as TDF and emtricitabine. Five participants became infected with HIV during the study. These participants had low, variable or undetectable drug levels, likely indicating they were not consistently using PrEP.

The researchers also reported results from a substudy evaluating the impact of these PrEP regimens on colorectal tissue samples from 55 participants. Previous work in HIV-infected people had suggested that maraviroc may increase immune T-cell activation in rectal tissue, which potentially could increase susceptibility to HIV infection. However, the researchers did not observe increased T-cell activation in the samples. Viral suppression experiments with tissue samples taken from study volunteers provided a preliminary indication that maraviroc alone may be less effective at preventing HIV infection than combination PrEP regimens.

The HPTN 069/ACTG 5305 investigators also are assessing the safety and tolerability of maraviroc-containing regimens in women at risk of sexually acquiring HIV. More information about the study is available on ClinicalTrials.gov using identifier NCT01505114.

References:

PRESENTATIONS:

Roy Gulick et al. HPTN 069/ACTG 5305: Phase II Study of Maraviroc-Based Regimens for HIV PrEP in MSM. Session: Expanding the Toolbox for Prevention

Ian McGowan et al. PrEP Impact on T-cell Activation and Explant Infection: HPTN 069/ACTG 5305 Substudy. Session: Expanding the Toolbox for Prevention

Meeting: 2016 Conference on Retroviruses and Opportunistic Infections

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

As many as 185,000 new HIV infections in the U.S. could be prevented by expanding testing, treatment, PrEP

CDC, blog.aids.gov | 2.25

Reaching the National HIV/AIDS Strategy (NHAS) targets for HIV testing and treatment and expanding the use of daily Pre-Exposure Prophylaxis (PrEP) could prevent an estimated 185,000 new HIV infections in the United States by 2020 – a 70 percent reduction in new infections, according to researchers at the Centers for Disease Control and Prevention (CDC).

The study, presented today at the Conference on Retroviruses and Opportunistic Infections in Boston, uses a forecasting model to predict the impact of these key prevention strategies. Based on the reach of each strategy, CDC researchers examined the impact of fully achieving NHAS goals, as well as several alternate levels of success ([Graphic: Four Scenarios of the Potential Impact of Expanded HIV Testing, Treatment and PrEP in the US, 2015-2020](#)).

Reaching the nation's treatment goal of ensuring 80 percent of all of those diagnosed with HIV achieve viral suppression (that is, keeping their virus under control and at a level that dramatically reduces the risk of transmission) alone would prevent an estimated 168,000 infections over the next five years. Increasing the use of PrEP, a daily anti-HIV pill, among people who are uninfected but at high risk could prevent an additional 17,000 infections over the same time span.

Currently, however, less than a third of Americans with HIV are on sustained treatment that effectively keeps their virus suppressed. And too few people who are at substantial risk for HIV and who could benefit from PrEP are receiving it.

"If we expand the use of our current prevention strategies today, we can significantly reduce new HIV infections tomorrow," said Jonathan Mermin, M.D., director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention. "This study confirms that we have the right tools to dramatically reduce new HIV infections, but we have a long way to go in order to make those reductions a reality."

The study also models the impact increased PrEP use by people at high risk of infection could have at current levels of viral suppression in the U.S., when the risk of HIV transmission is substantially higher. If testing and treatment rates were to remain the same over the next five years, expanding PrEP coverage alone could reduce new infections by nearly 20 percent, preventing more than 48,000 new HIV infections. Results suggest that as the nation works to expand the reach of HIV treatment, PrEP can play a critical role in protecting those currently at high risk for HIV infection.

"We urgently need to close gaps in HIV care and treatment for people living with HIV," said Eugene McCray, M.D., director of CDC's Division of HIV/AIDS Prevention. "At the same time, in the short term, we need to rapidly expand access to PrEP and other life-saving prevention tools."

Researchers also presented interim scenarios, examining the potential impact of reaching 60 percent of those living with HIV with effective treatment and viral suppression. Even this level of success would substantially reduce new infections.

Findings from the study highlight the importance of implementing the National HIV/AIDS Strategy, which sets ambitious goals to inspire and mobilize the national response to the epidemic. First issued in 2010 with 2015 targets, the Strategy was recently updated through 2020.

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

What Are the Odds You'll Get HIV in Your Lifetime? A New CDC Study Breaks It Down

Myles Helfand, TheBodyPRO.com | 2.23

It's one thing to tell people they're at risk for HIV. But if you can tell them the exact statistical risk that they'll get HIV in their lifetime, the message suddenly gets a lot more real. At least that's one of the assumptions behind a new, detailed breakdown of estimated lifetime HIV risk in the U.S. released on Feb. 23 by the U.S. Centers for Disease Control and Prevention (CDC).

The new numbers cast in sharp relief the extent to which HIV rates differ in the U.S. by race, sex and state. They range from a stunningly high lifetime risk of 1 in 2 for black men who have sex with men (MSM), to a relatively low risk of 1 in 883 for Asian women -- and from 1 in 13 for District of Columbia residents, to 1 in 670 for those who live in North Dakota.

The estimates, which were presented in an oral abstract presentation at CROI 2016 in Boston, are based on a combined analysis of reported HIV diagnoses from the National HIV Surveillance System, non-HIV death rates from the National Center for Health Statistics, and U.S. census data between 2009 and 2013. The analysis found that the overall HIV risk for people in the U.S. was now 1 in 99, a reduction from the 1-in-78 rate found in an earlier analysis of 2004-2005 data.

But that roughly 1% lifetime risk belies dramatic differences by subpopulation. A [new fact sheet](#) released by the CDC shortly after the CROI 2016 presentation highlights key research findings in bar graphs, showing comparative HIV diagnosis rates by transmission group:

[Click here to see the included graphics.](#)

The fact sheet did not include all of the data points presented at CROI 2016, which identified the following lifetime HIV diagnosis risks among males:

- Males overall: 1 in 64
- Black males: 1 in 20
- Hispanic/Latino males: 1 in 48
- Native Hawaiian and Pacific Islander males: 1 in 82
- American Indian and Alaska Native males: 1 in 129
- White males: 1 in 132
- Asian males: 1 in 174

And the following lifetime HIV diagnosis risks among females:

- Females overall: 1 in 227
- Black females: 1 in 48
- Hispanic/Latino females: 1 in 227
- Native Hawaiian and Pacific Islander females: 1 in 385
- American Indian and Alaska Native females: 1 in 399
- White females: 1 in 880
- Asian females: 1 in 883

When assessing lifetime risk among males and females, the study did not account for transgender people, according to Kristen Hess, Ph.D., the lead author of the study who presented the data at CROI 2016.

Among MSM in particular, rates remained very high across racial/ethnic boundaries:

- MSM overall: 1 in 6
- Black MSM: 1 in 2

- Hispanic/Latino MSM: 1 in 4
- Native Hawaiian and Pacific Islander MSM: 1 in 7
- American Indian and Alaska Native MSM: 1 in 12
- White MSM: 1 in 11
- Asian MSM: 1 in 14

Although the study findings are not necessarily surprising in and of themselves -- the data have long shown which U.S. subpopulations are at higher risk for HIV -- this new depiction of lifetime risk "can more effectively communicate the level of risk and large disparities to the general public," Hess said. "This can be a useful tool for clinicians, outreach workers and policy workers."

At a press conference discussing the findings, Susan P. Buchbinder, M.D., of the University of California San Francisco concurred: "I think that what this points to is that we really need to be doing more aggressive programming and outreach to people who are in our most vulnerable populations," she said. "We do have very highly effective prevention, and we can change those numbers."

Buchbinder also spoke about the sex discrepancy in the lifetime risk for injection drug users. "Women are probably at risk both through sexual practices -- which may not be sex work, but could be survival sex -- but also because there are some studies that suggest that men go first when they're injecting and then the women get the injection equipment afterwards, so they're more likely to be infected that way as well," she said. "I think that there's always these issues of power dynamics in relationships."

The study authors noted some key limitations to the study findings, including the fact that HIV data focused on diagnoses (which are officially reported), not incidence, and thus would miss unreported infections. They also noted that the wide timespan of the data -- 2009 to 2013 -- assumed that there was no change in a person's risk trend during that period.

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

CDC guidelines on STI testing for PrEP patients may miss cases

Gerard Gallagher, Healio Infectious Disease News | 2.25

CDC guidelines regarding testing for sexually transmitted infections among patients assigned pre-exposure prophylaxis may need revision after researchers showed that following them would have missed a significant number of asymptomatic cases.

"The reason that this is so important right now is that ... PrEP implementation is exploding in the U.S.; it's expanding very rapidly," Sarit A. Golub, PhD, MPH, of Hunter College and the Graduate Center at City University of New York, said during a press event at CROI 2016. "We need these guidelines now because it is much harder to tell providers to change their practice once they've already started it than it is to get them to start with the practice that we like to see."

Golub and colleagues studied 280 patients who began PrEP in SPARK, a community-based PrEP demonstration project affiliated with Callen-Lorde Community Health Center in New York. The patients were screened every 3 months for STIs or during visits between screenings if they were symptomatic. This practice was a departure from CDC guidelines that call for screening every 6 months unless patients report symptoms.

At 3 months, 77% of the patients who had an STI were diagnosed during a routine screening that would not have been performed under CDC guidelines, the investigators reported, rather than a symptomatic presentation. In addition, Golub and colleagues noted, only 33% of the patients with an STI at their 3-month follow-up visit had a prior history of STI that would have warranted screening. Further, 68% of the patients with an STI at 9 months were diagnosed during routine screening rather than a symptomatic presentation that would have been necessary to trigger testing at 9 months under CDC guidelines.

“Even though the percentage of patients with repeat STI diagnoses increased over time, basing STI screening on prior diagnosis at the 9-month visit would have missed 16% of STI cases,” Golub and colleagues wrote. “Overall, STI screening according to current CDC guidelines would have delayed diagnosis and treatment for 24% of PrEP patients, including 40 cases of rectal STI and three cases of syphilis.”

Golub said there is “tremendous potential” for a long-term reduction in STI prevalence because of the potential of PrEP to identify more cases. Further reduction can be achieved through contact tracing, she said.

“We are getting PrEP to the people who need it most, to folks who are consistently vulnerable to infection, but I want to stress that because of that, testing and treatment is critical, both for PrEP patients themselves and for their partners.”

Reference:

Golub SA, et al. Abstract 869. Presented at: Conference on Retroviruses and Opportunistic Infections; Feb. 22-25, 2016; Boston.

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

Scientific Papers/Conference Abstracts

Characteristics Associated With Urethral and Rectal Gonorrhea and Chlamydia Diagnoses in a US National Sample of Gay and Bisexual Men: Results From the One Thousand Strong Panel

Grov C, Cain D, Rendina HJ, et al. *Sex Transm Dis* 2016;43(3):165-171

Background:

Gay and bisexual men are at elevated risk for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* (GC/CT). Rectal GC/CT symptoms may be less obvious than urethral, increasing opportunities for undiagnosed rectal GC/CT.

Methods:

A US national sample of 1071 gay and bisexual men completed urethral and rectal GC/CT testing and an online survey.

Results:

In total, 6.2% were GC/CT positive (5.3% rectal, 1.7% urethral). We calculated adjusted (for education, race, age, relationship status, having health insurance, and income) odds ratios for factors associated with rectal and urethral GC/CT diagnoses. Age was inversely associated with urethral and rectal GC/CT. Compared with white men, Latinos had significantly greater odds of rectal GC/CT. Among men who reported anal sex, those reporting only insertive sex had lower odds of rectal GC/CT than did men who reported both insertive and receptive. There was a positive association between rectal GC/CT and number of male partners (<12 months), the number of anal receptive acts, receptive condomless anal sex (CAS) acts, and insertive CAS acts. Compared with those who had engaged in both insertive and receptive anal sex, those who engaged in only receptive anal sex had lower odds of urethral GC/CT. The number of male partners (<12 months) was associated with increased odds of urethral GC/CT.

Conclusions:

Rectal GC/CT was more common than urethral and associated with some demographic and behavioral characteristics. Our finding that insertive CAS acts was associated with rectal GC/CT highlights that providers should screen patients for GC/CT via a full range of transmission routes, lest GC/CT go undiagnosed.

View the paper online: [Abstract](#)

Racial Differences in Receipt of Chlamydia Testing Among Medicaid-Insured Women in 2013

Patel CG, Chesson HW, Tao G. *Sex Transm Dis* 2016;43(3):147-151

Objective:

To estimate the percentage of young, sexually active Medicaid-insured women who were tested for chlamydia by age, race/ethnicity, and history of sexually transmitted disease (STD) diagnosis.

Methods:

We used the medical diagnostic and procedural codes from Truven Health MarketScan Medicaid claims data from 10 states in 2012 and 2013 to estimate the rates of chlamydia testing in 2013 and previous STD diagnosis (diagnosed in 2012) among Medicaid-insured women aged 15–25 years who were sexually active in 2013. We also used a logit model to assess the association between chlamydia testing and women's age, race/ethnicity, and previous STD diagnosis.

Results:

Overall, among approximately 261,000 Medicaid-insured women aged 15–25 years in 2013 who were classified as sexually active, 50.2% were tested for chlamydia in 2013. The chlamydia testing rate was 45.6% for white women and 57.5% for black women. The chlamydia testing rate was 63.5% for women diagnosed as having an STD in 2012 and 46.8% for women not diagnosed as having an STD in 2012. The chlamydia testing rate was significantly ($P < 0.05$) associated with previous STD diagnosis, age, and race/ethnicity in our logit model.

Conclusions:

Higher chlamydia testing rates among black women can be explained in part by higher rates of previous STD diagnoses. Our finding that black women have the highest chlamydia testing rates is encouraging, as improved access to STD prevention services among racial/ethnic minorities can help to reduce

racial/ethnic disparities in STDs. However, chlamydia screening remains an underused preventive health service for young women of all racial and ethnic groups.

View the paper online: [Abstract](#)

Can Young Adults Accurately Report Sexual Partnership Dates? Factors Associated With Interpartner and Dyad Agreement.

Sanchez DM, Schoenbach VJ, Harvey SM, et al. *Sex Transm Dis* 2016; [Epub ahead of print]

Background:

Sexual partnership dates are critical to sexually transmitted infection/HIV research and control programs, although validity is limited by inaccurate recall and reporting.

Methods:

We examined data from 302 heterosexual adults (151 index-partner dyads) to assess reliability of reporting. Dates of first sex and last sex were collected through individual interviews and joint dyad questionnaires, which were completed together with their partners. We compared index- and partner-reported dates to estimate interpartner agreement. We used log-linear regression to model associations between interpartner differences and partnership characteristics. To assess validity, we compared individually reported dates with those from joint dyad questionnaires.

Results:

Most partnerships (66.2%) were 2 years or less in duration, and many (36.2%) were nonmonogamous. Interpartner agreement to within 1, 30, and 365 days was, respectively, 5.6%, 43.1%, and 81.3% for first sex, and 32.9%, 94.5%, and 100.0% for last sex. In adjusted models, longer relationship duration was associated with disagreement on first sex dates; partnership nonmonogamy was associated with disagreement on dates of first sex and last sex. Within dyads, several participant characteristics were associated with reporting dates closer to joint dyad responses (e.g., for first sex date, female sex [54.7%], having fewer sex partners [58.5%], and greater relationship commitment [57.3%]). However, percent agreement to within 30, 60, and 90 days was similar for all groups for both first and last sex dates.

Conclusions:

Agreement was high on date of last sex but only moderate on date of first sex. Methods to increase accuracy of reporting of dates of sex may improve STI research.

View the paper online: [Abstract](#)

HIV Incidence Among Men Who Have Sex With Men After Diagnosis With Sexually Transmitted Infections.

Katz DA, Dombrowski JC, Bell TR, et al. *Sex Transm Dis* 2016; [Epub ahead of print]

Background:

Men who have sex with men (MSM) are at high risk for acquiring HIV infection after diagnosis with other sexually transmitted infections (STIs). Identifying the STIs associated with the greatest risk of subsequent HIV infection could help target prevention interventions, particularly preexposure prophylaxis (PrEP).

Methods:

Using matched HIV and STI surveillance data from Washington State from January 1, 2007, to June 30, 2013, we calculated the incidence of new HIV diagnoses after different STI diagnoses among MSM. Men entered observation at the time of their first STI diagnosis during the study period and exited at HIV diagnosis or June 30, 2013. Cox proportional hazards regression was used to conduct a global comparison of rates.

Results:

From January 1, 2007, to June 30, 2013, 6577 HIV-negative MSM were diagnosed as having 10,080 bacterial STIs at 8371 unique time points and followed for 17,419 person-years. Two hundred eighty (4.3%) men were subsequently diagnosed as having HIV infection for an overall incidence of 1.6 per 100 person-years (95% confidence interval, 1.4-1.8). The estimated incidence of HIV diagnoses among all MSM in the state was 0.4 per 100 person-years. Men who have sex with men were at the greatest risk for HIV diagnosis after being diagnosed as having rectal gonorrhea (HIV incidence, 4.1 per 100 person-years), followed by early syphilis (2.8), urethral gonorrhea (1.6), rectal chlamydial infection (1.6), pharyngeal gonorrhea (1.1), late syphilis (1.0), and urethral chlamydial infection (0.6; $P < 0.0001$ overall).

Conclusions:

Men who have sex with men diagnosed as having rectal gonorrhea and early syphilis were at the greatest risk for being diagnosed as having HIV infection after STI diagnosis. These men should be prioritized for more intensive prevention interventions, including PrEP.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

March 10 Is National Women and Girls HIV/AIDS Awareness Day

Office on Women's Health

Today, it's possible to reduce the risk of getting HIV or passing the virus to your partner or baby. But women still face unique challenges in preventing HIV infections. Join us on March 10, 2016, for **National Women and Girls HIV/AIDS Awareness Day**. This year's theme, "The Best Defense Is a Good Offense," is all about HIV prevention.

When it comes to sex, abstinence is the surest way to prevent HIV infection. If you do have sex, there are a [dozen ways to lower your risk of getting HIV](#).

Visit the [National Women and Girls HIV/AIDS Awareness Day website](#) to learn more about the activities happening on March 10, 2016, and to take a sneak peek at our brand new graphics and materials.

NCC Adds 2014 HEDIS Data to Website

NCC

The National Chlamydia Coalition has added 2014 HEDIS data to its [Quality Measures & Screening Recommendations](#) webpage.

Screening data is presented for commercial HMOs, commercial PPOs, and Medicaid HMOs. In 2014, Medicaid HMOs had the highest screening rates with 51.2% of women aged 16-20 and 60.1% of women aged 21-24 years being screened for chlamydia. Commercial PPOs had the lowest screening rates with only 38.3% of women aged 16-20 and 46.7% of women aged 21-24 years being screened for chlamydia.

[HEDIS data at the national and state level](#) is also available for 2000-2014. The data shows that in 2014, half of sexually active women aged 16-25 years enrolled in health plans were screened for chlamydia. This is a significant increase from only 25.4% in 2000. Similar increases in screening rates are reported by state. Although demonstrating that providers are screening more of their female patients for chlamydia, half of eligible young women are still not being screened.

CDC Releases Updated Technology-Based Partners Services Toolkit

NCC

A new resource, [Introducing Technology into Partner Services: A Toolkit for Programs](#), was released by CDC recently. The toolkit outlines best practices and experiences from organizations who are integrating technology into their partner services activities. Technology, including the internet, mobile devices, email, instant messaging, and social media and networking sites, can be a powerful component of a program's array of partner services.

CROI Round-Up; Post-Conference Webinar Series Starts March 1st

AVAC

Dear Advocates,

News last week from the [Conference on Retroviruses and Opportunistic Infections \(CROI\)](#) in Boston was dominated by new efficacy data from two vaginal ring trials that have implications for HIV prevention for women. [Our take on it is here](#), along with a [special page](#) with more background than we could squeeze into a blog post. But, the CROI buzz wasn't all about vaginal rings, and this update provides some ways to hear more about what happened last week and what it all means.

Post-CROI Webinar Series

The first in a series of post-CROI webinars that will cover a range of topics over the next couple of months is on Tuesday. This webinar, which will explore the ring results with advocates and researchers, is **Tuesday, March 1, 8–9am US ET** (see www.timeanddate.com for the time in your area). [Register here](#). And stay tuned for details about the additional webinars in the series!

In-Depth Analysis

In addition to lots of media reports and publications, our colleagues at [NAM/aidsmap](#), [The Body](#) and [NATAP](#) all provided in-depth coverage of the myriad studies presented in oral abstract sessions, posters and more. Check out the hyperlinks above for comprehensive coverage.

CROI Program and Webcast

CROI provides a number of ways to review what happened in Boston: check out the [full program](#); taped playbacks of [press conferences](#); [webcasts of all sessions](#); and [electronic posters](#) will be available a week after the conference.

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

DATE: March 10

TIME: 1:00 – 2:00 PM ET

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

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

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

For more information: [Click here](#)

Job/Internship Postings

Health Policy and Health Services Research Program Officer - CHRP

Organization: CHRP

App. Deadline: March 7

Job Title: Health Policy and Health Services Research Program Officer

Job Description: This position has primary responsibility in the area of health policy and health services research in the California HIV/AIDS Research Program (CHRP), including program development and planning, peer reviewer and applicant relations, grant application and award management, and representing the program and disseminating research findings to a broad range of organizations and institutions concerned with HIV/AIDS-related issues. This position also serves as the primary CHRP

liaison to the RGPO Communications and Dissemination Center of Excellence (COE), maintaining expertise and contributing to innovation in research dissemination, including collaborative development of dissemination procedures and tools. Please view the job listing and submit an application through the University of California, Office of the President.

Organization Description: CHRP staff are members of the Research Grants Program Office (RGPO) within the Office of Research and Graduate Studies (ORGS). The RGPO consists of several grant-giving programs that are administered by the University for the University of California or on behalf of the State of California. These programs are the California Breast Cancer Research Program, the Tobacco-Related Disease Research Program, the California HIV/AIDS Research Program, and the UC Research Initiatives such as the Multicampus Research Programs and Initiatives and the Lab Fee Research Program. The RGPO provides central administrative units to support grant review and administration, financial and budgetary services, database management, and other core administrative needs to all of the grant programs. These services are provided by the Grants Budget, Finance and Administration Unit and the Contract and Grants Unit.

Required Skills:

1. Earned doctorate degree in a relevant area of health policy, health services research, social/behavioral sciences, public health, or political science. Ten years of relevant experience required, with at least three in research in the field of the degree, or an equivalent level of education and experience.
2. In depth academic background and experience in selected area of research including record of publications in related field(s) required.
3. Extensive knowledge and understanding of issues in disease-related research program management, science and health policy, and research program evaluation. Demonstrated knowledge of and experience related to the translation and dissemination of research findings to applied, community or commercial uses. State-of-the-art knowledge of health policy and health services research, particularly in relation to HIV/AIDS.
4. Skill in analyzing information, problems, situations, policies, or procedures to define the problem, need or objective, identifying relevant issues or concerns, formulating alternatives for resolution or new program development, and recommending alternative choices and implications for implementation. Proven ability to formulate solutions, new program development, alternative choices and implications for implementation.
5. Advanced interpersonal skills and ability to work with diverse groups to achieve results. Demonstrated experience and commitment to working in collaborative teams and in positions with shared authority for accomplishing program goals.
6. Demonstrated ability to work collaboratively with internal and external peers, managers and teams. Ability to establish and maintain cooperative and mutually supportive working relationships with faculty, administrators, staff, other campus units, UC system units and sponsoring agencies.
7. Advanced program planning and management of projects.

8. Demonstrated excellent written and oral communication skills to ensure effective communication with a wide audience (e.g., scientists, staff, industry, community agencies, funding agencies and the general public). Advanced skills analyzing information, problems, situations, policies or procedures to define the problem, need or objective.

9. Proven leadership ability in scientific program planning and management of projects; experience leading scientific committees, outreach and technical assistance teams, peer review committees, and internal and external staff.

10. Incorporate effective listening skills. Maintain a positive attitude.

Preferred Skills:

1. Conduct of research in HIV/AIDS and a record of publications in the field.

2. Experience as program or grant officer managing a multi-million dollar research portfolio.

3. Knowledge of UCOP research policies, documents and bulletins, grant management database systems, UCLA business and finance policies and bulletins, and/or the UCLA Accounting policies and procedures.

Application Deadline/Closing Date: Monday, March 7, 2016

How to Apply:

The job/organization description is listed on the CHRP

website: <http://www.californiaaidsresearch.org/about/job-opportunities.html>

Applicants should submit applications through the University of California, Office of the President employment

site: <https://jobs.ucop.edu/applicants/jsp/shared/frameset/Frameset.jsp?time=1456429403878>

Aaron Kavanaugh

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Archives of previous STD Updates can be found [here](#). To unsubscribe or add colleagues' names, email aaron.kavanaugh@cdphc.a.gov. 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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