PARTNER SERVICES FOR GONORRHEA CAN DECREASE NEW HIV AMONG MSM IN KING COUNTY, WASHINGTON: A MATHEMATICAL MODELING STUDY

Gu Liu*, Cara Broshkevitch, David Katz, Rachel Silverman, Matthew Golden, Roxanne Barnabas. 1University of Washington, Department of Epidemiology, Seattle, USA; 2University of Washington, Seattle, Washington, USA; 3University of Washington, Global Health, Seattle, USA; 4University of Washington, Medicine, Seattle, USA

Background Partner services (PS) for bacterial STIs has potential to increase STI treatment among infected sex partners and HIV testing among people diagnosed with STIs and their partners. The population-level impact of PS on gonorrhea and HIV incidence has not been estimated.

Methods Calibrated to King County’s MSM population, our compartmental gonorrhea-HIV coinfection model captures sexual mixing, gonorrhea and HIV transmission, and scale-up of antiretroviral therapy (ART), pre-exposure prophylaxis (PrEP), and routine STI screening. We assessed incremental impact of PS over 5 and 20 years, and compared gonorrhea and HIV incidence and prevalence without PS, with PS, and with PS that integrates promotion of HIV testing (PS+HIV). In the absence of PS, we assumed that 10%, 10%, and 95% of rectal, pharyngeal, and urethral gonorrhea were treated and 63% of MSM receiving gonorrhea treatment also received HIV testing. With PS, 40% of treated cases received PS, increasing the proportion of partners treated for gonorrhea and tested for HIV by 4%, 4%, and 38% at each site. PS+HIV increased the proportion of gonorrhea-infected MSM tested for HIV to 83%.

Results After 5 and 20 years, PS modestly changed rectal, pharyngeal, and urethral gonorrhea incidence and prevalence (<7%). After 5 years, HIV prevalence decreased 0.1% with PS and 0.5% with PS+HIV. HIV incidence decreased 6.0% (from 187.1 to 176.0 per 100,000 persons) with PS and 14.7% (187.1 to 159.6/100,000) with PS+HIV. After 20 years, HIV prevalence decreased 3.2% with PS and 5.6% with PS+HIV. PS reduced incidence 23.3% (75.2 to 57.7/100,000) and PS+HIV 37.7% (75.2 to 46.9/100,000).

Conclusion Moderate gonorrhea PS coverage had modest impact on gonorrhea, given high rates of STI testing and treatment in King County. However, long-term PS+HIV increased HIV testing opportunities and substantially reduced HIV incidence. PS+HIV is a potential approach for prioritizing HIV testing in high ART and PrEP coverage settings.

Disclosure No significant relationships.

Molecular Epidemiology of HIV Among Foreign-Born Residents of King County, Washington, USA, Using HIV Surveillance Data

Diana Tordoff*, Joshua Herbeck, Susan Buskin, Richard Lechtenberg, Matthew Golden, Roxanne Kerani. 1University of Washington, Department of Epidemiology, Seattle, USA; 2University of Washington, Department of Global Health, Seattle, USA; 3Public Health – Seattle and King County, Seattle, USA; 4University of Washington, Medicine, Seattle, USA; 5Public Health – Seattle and King County, HIV/STD Program, Seattle, USA

Background In King County, one-third of HIV diagnoses occur among foreign-born individuals, a 50% increase since 2010. The extent to which these infections are locally acquired is unclear, but has important implications for HIV prevention and incidence estimation.

Methods Using HIV surveillance (2010–2018) and partner services (PS) (2010–2016) data from Public Health–Seattle & King County, HIV-1 pol gene sequences from routine drug resistance testing were linked to demographic, clinical, and epidemiological information. We identified genetic similarity clusters of 2+ individuals using TN93 pairwise genetic distance with a 0.02 threshold. Belonging to a cluster is suggestive of local transmission, therefore correlates of clustering were identified using logistic regression, adjusted for early infection (CD4 >500 cells/mm at diagnosis). We also calculated the proportion of foreign-born cases with a negative HIV test in the U.S. before diagnosis.

Results From 2010–2018, 2,521 people were diagnosed with HIV in King County: 663 (26%) occurred among foreign-born individuals, primarily from Latin America (N=232), sub-Saharan Africa (SSA) (N=214), and Asia (N=98). Among individuals with a PS interview (75% Latin American, 56% SSA, 69% Asian-born), HIV testing histories suggest that 40% of Latin American, 19% of SSA, and 36% of Asian-born individuals likely acquired HIV locally. Individuals with non-B HIV subtypes similarly varied by region of birth: 2% of US, 5% of Latin American, 93% of SSA, and 46% of Asian-born people. Among 1,754 individuals with an available sequence (70% US versus 63% of foreign-born), 1,092 (62%) clustered in 304 genetically similar clusters. Odds of clustering, compared to US-born, was 0.44 (95% CI: 0.31,0.60) among Latin American, 0.08 (95% CI: 0.05,0.14) among SSA, and 0.40 (95% CI: 0.24,0.66) among Asian-born.

Conclusion Our results suggest that local HIV acquisition occurs least frequently among SSA-born, followed by Asian-born and Latin American immigrants. Incident estimates that include all diagnoses among foreign-born people may overestimate HIV incidence.

Disclosure No significant relationships.
group-specific STI prevalence with and without turnover, and compared the fitted partner change rates and transmission population attributable fraction (tPAF) of the core group to cumulative STI infections in the total population.

**Results** Across the range of turnover and treatment parameters explored, turnover consistently decreased STI prevalence in the core group. In the low-risk group, turnover increased prevalence under low treatment rate, but had the opposite effect under high treatment rate. When calibrating to the same STI prevalence, fitted core group partner change rates were higher with turnover than without. Using these fitted parameters, models with turnover then consistently projected a higher tPAF of the core group versus models without.

**Conclusion** Modeling of risk group turnover can influence the projected group-specific STI prevalence and fitted risk parameters. Models without turnover may underestimate the contribution of core groups in STI epidemics, and thus the impact of interventions prioritizing these populations.

**Disclosure** No significant relationships.

---

**Poster Presentations**

**PS01 — POSTER VIEWING SESSION — MONDAY**

**Monday, July 15, 2019**

**5:45 PM — 7:00 PM**

---

**P004**

**THE NATIONWIDE ANTIMICROBIAL RESISTANCE SURVEILLANCE SYSTEM OF SEXUALLY TRANSMITTED INFECTIONS — SOUTH KOREA, 2017–2018**

**Background** The Korea Centers for Disease Control and Prevention established the new nationwide surveillance system and conducted the first nationwide surveillance of antimicrobial resistance for three major sexually transmitted pathogens; *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, and *Mycoplasma genitalium*.

**Methods** The urethral discharge was collected from male patients with urethritis at 20 primary urologic clinics from January 2017 to December 2018. The cervical swab was collected from female patients with cervicitis at 8 primary gynecological clinics from January to December 2018. All specimens were sent to the 4 regional or the central laboratories.

**Results** A total of 224 *N. gonorrhoeae* isolates were collected. Of these, 90.6% were resistant to tetracycline, 95.3% to ciprofloxacin, and 58.0% to penicillin. None of the strains were resistant to ceftriaxone and spectinomycin. The minimum inhibitory concentration (MIC) range of ceftriaxone was ≤0.008–0.25 µg/mL and the MIC50 and MIC90 were 0.06 µg/mL and 0.12 µg/mL. Twenty-two strains were resistant to cefixime (MIC 0.5 µg/mL). Most of the penA genotypes were type X. In particular, the proportion of mosaicism in DNA specimens has been steadily increasing, and the spread of penA-34.001 was confirmed in 2018. Reduced azithromycin susceptibility (defined MIC ≥1.0 µg/mL) increased from 0% in 2017 to 13% in 2018. The MIC range, MIC50 and