

cytology (ASC-H or HSIL) in 6/9 patients. There was 1 newly diagnosed HIV infection. There were 6 incident syphilis infections. Demographic and sexual behaviour data and correlates of HGAIN will be presented.

Conclusion High risk anal HPV infection and HGAIN was highly prevalent at baseline within this cohort of Asian MSM reinforcing the importance of screening within this population.

Disclosure of interest The study was funded by grant from TreatAsia.

P17.18 FACTORS PREDICTING THE OCCURRENCE OF TUBERCULOSIS FOLLOWING INITIATION OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART)

B Achappa*. *Department of Internal Medicine, KMC, Mangalore Affiliated to Manipal University*

10.1136/sextrans-2015-052270.596

Background HIV infection is the greatest risk factor for progression of latent Tuberculosis (TB) infection to active TB. Co-infection with these two pathogens is the greatest cause of death in HIV/AIDS patients. TB may develop or latent TB may become active following initiation of HAART. This study was done to evaluate risk factors contributing to development of active TB following initiation of HAART, to detect prevalence of latent TB in treatment naïve patients and to correlate latent TB at initiation of HAART to development of active TB during first year of treatment.

Methods This hospital based follow up study done over two years period (2013–14) included 48 treatment naïve patients initiated on HAART (2NRTI +1NNRTI). All subjects were screened at baseline for CD4 count, ESR, Quantiferon TB Gold test, BMI, past history of TB and followed up every three months for 1 year. Data collected was analysed using SPSS Version 11.5 statistical software.

Results 79% of patients were 31–50 years of age. 30 were males and 18 females.

20.83% patients developed TB within 1 year of initiation of HAART. 23 (47.9%) had latent TB (positive Quantiferon TB Gold test). Of these, 8 (30%) patients eventually developed TB, whereas 2 (8%) of patients with negative Quantiferon TB Gold test developed TB which was statistically significant.

7 (70%) patients who developed active TB at end of study had CD4 T-cell count of less than 200/ μ l. 13 out of 23 patients of latent TB and 6 out of 10 with active TB had BMI <18.5. 7 out of 18 latent TB patients who developed active TB had ESR above 40 mm/1stHr.

Conclusion Prevalence of latent TB is high in patients being initiated on HAART.

TB is more likely to develop in patients with lower BMI, higher ESR, lower CD4 count and Quantiferon TB Gold test positivity at baseline after initiation of HAART.

Disclosure of interest None.

P17.19 TIME TO LINKAGE, RETENTION AND ADHERENCE TO HIV CARE AMONG MARRIED COUPLES IN THE FISHING COMMUNITIES ON LAKE VICTORIA

Zachary Kwenya*, Phoebe Olugo, David Angawa, Elizabeth Bukusi. *Research, Care and Training Program, Kenya Medical Research Institute, Nairobi, Kenya*

10.1136/sextrans-2015-052270.597

Background Prompt linkage to care, retention in care and adherence to medication are important in achieving the WHO's 90–90–90 treatment target. Achieving these targets is important for treatment and prevention of new infections. We sought to establish the time to linkage to care, retention in care and adherence to HIV medications in a cohort of people testing HIV positive in the fishing communities on Lake Victoria.

Methods We conducted a 2-year resurvey of 128 participants who had tested HIV positive in a previous study. These participants were asked to return to the study clinic to participate in a follow-up study. Returning participants were consented and invited for a face-to-face interview on enrolment into HIV care, time to enrolment, retention in care and adherence to HIV care instructions. We mainly used descriptive statistics to analyse the data.

Results Of 128 participants, 47.7% were female and half were aged 33.5 (IQR, 29–38.7) with a median monthly income of \$66 (IQR, 33–99). Eighty three percent had enrolled in HIV care within a median of 20 days (IQR, 7–60) after testing HIV positive. Women were more likely to enrol in care compared to men (91.8% vs 74.6%; $p = 0.011$) but no significant difference in time taken to enrol in care. Over 38% of the participants had ever missed their clinic appointments since they first enrolled into care with half having missed 2 appointments (IQR, 1–3.5) in the preceding 12 months. Similarly, 26% had ever missed taking medications as prescribed with half having missed twice (IQR, 1–8.5) in the preceding 12 months. The most common reason cited for both missing clinic appointments and taking medications prescribed was travelling away from home.

Conclusion The numbers enrolled into care falls below the expected 90% to achieve 90–90–90 treatment target by WHO. More innovative ways need to be developed to achieve these targets.

Disclosure of interest statement This research was supported by a grant from the Consortium for National Health Research. No pharmaceutical grants were received in the development of this study.

P17.20 PATIENT PERSPECTIVES ON THE HIV TREATMENT CASCADE IN THE UNITED KINGDOM

¹T Rai, ¹J Bruton, ²C Higgs, ²J Rowlands, ¹H Ward*. *¹Imperial College London; ²Chelsea and Westminster NHS Foundation Trust, London*

10.1136/sextrans-2015-052270.598

Introduction Figures for the UK's HIV treatment cascade are among the best worldwide with over 95% retention once in care, however guidelines and service models are changing. We examine perspectives on each stage of the cascade among four generations of patients.

Methods In-depth interviews with 48 HIV-positive adults from two clinics. Participants were purposively selected from the four 'HIV generations', based on ART development – those diagnosed pre-1996, 1997–2005, 2006–2012, and since 2013. Framework was used to analyse the data.

Results *Diagnosis* - Participants from the pre-treatment era were diagnosed on the development of AIDS-defining symptoms, or following a partner's diagnosis. Late diagnoses more recently were because patients underestimated their own risk or failures of healthcare professionals to spot indicator conditions.

Linkage with care - Earlier generations sometimes disengaged with care for a period following diagnosis, dismayed by limited

treatment options. In contrast, those diagnosed since 2005 linked to care promptly and felt they received appropriate medical attention.

Retention in care - Across the generations, once linked to care participants were committed to attending appointments and taking medications. Occasional lapses were explained by external issues such as drug misuse or household disruption, rather than their relationship with the clinic. Some reported concern at the recently reduced frequency of appointments, and the increasing role of primary care.

Viral suppression among those on ART - Most participants on ART had undetectable viral load and good adherence. Actual or anticipated co-morbidities worried them more than HIV, however, wider discussions about NHS cost-cutting have raised patient anxiety about accessing the 'best' treatments.

Conclusion The high standard of UK's HIV treatment cascade reflects strong relationships between patients and staff, which service changes could undermine. Being sensitive to how patients experience different stages of decision-making and the wider influences on their behaviour is vital towards sustaining high retention along the cascade.

Disclosure of interest statement This study is funded by a grant from the Imperial NIHR BRC and the Imperial Healthcare Charity. No pharmaceutical grants were received in the development of this study.

P17.21 FAILURE TO ENGAGE AS KEY FACTOR OF LOSS TO FOLLOW-UP FROM CARE AND TREATMENT AMONG HIV-INFECTED CHILDREN IN BOTSWANA: A CASE-CONTROL STUDY

^{1,2}EM Machine*, ¹SL Gillespie, ²N Homedes, ²B Selwyn, ²MW Ross, ^{1,3}G Anabwani, ¹G Schutze, ¹M Kline. ¹Baylor College of Medicine; ²University of Texas School of Public Health; ³Botswana-Baylor Children's Clinical Centre of Excellence

10.1136/sextrans-2015-052270.599

Introduction Loss to follow-up (LTFU) is a critical factor in determining clinical outcome in HIV treatment programs. Identifying modifiable factors of LTFU is fundamental for designing effective patient retention interventions. We analysed factors contributing to children LTFU from a treatment program to identify those that can be modified.

Methods A case-control study involving 313 children was used to compare the sociodemographic and clinical characteristics of children LTFU (cases) with those remaining in care (controls) at a large paediatric HIV care setting in Botswana. We traced children through caregiver contacts and those we found, we conducted structured interviews with the patients' caregivers.

Results Children < 5 years were twice as likely as older children to be LTFU (20.6% vs. 7.8% and 79.4% vs. 92.2% respectively, $p < 0.01$). Approximately half (47.6%, $n = 51$) of LTFU patients failed to further engage in care after just one clinic visit, as compared to less than 1% ($n = 2$) in the control group ($p < 0.01$). Patients LTFU were more likely than controls to have advanced disease, greater immunosuppression, and not to be receiving Antiretroviral Therapy (ART). Among interviewed patient caregivers, psychosocial factors (e.g. stigma, religious beliefs, child rebellion, disclosure of HIV status) were characteristic of patients LTFU, but not of controls. Socioeconomic factors (e.g. lack of transportation, school-related activities, forgetting appointments) were cited predominantly by the controls.

Conclusion Paediatric patients and their caregivers need to be targeted and engaged at their initial clinic visit, with special attention to children <5 years. Possible interventions include providing psychosocial support for issues that deter patients from engaging with the clinic. Collaboration with community-based organisations focused on reducing stigma may be useful in addressing these complex issues.

Disclosure of interest statement Funding for this study was made possible through Fogarty International Centre of the National Institutes of Health, (M. W. Kline – Principal Investigator) under grant number D43 TW01036.

P17.22 PROVIDERS' PERCEPTIONS OF THE CAUSES OF LOSS TO FOLLOW-UP OF HIV-INFECTED CHILDREN IN BOTSWANA

^{1,2}EM Machine*, ¹SL Gillespie, ²N Homedes, ²MW Ross, ²BJ Selwyn, ^{1,3}GM Anabwani, ¹MW Kline. ¹Baylor College of Medicine; ²University of Texas School of Public Health; ³Botswana-Baylor Children's Clinical Centre of Excellence

10.1136/sextrans-2015-052270.600

Introduction Healthcare providers (nurses, physicians, and social workers), by virtue of their experiences in interacting with HIV-infected children and their caregivers, are an important source of information on the causes of loss to follow-up (LTFU). We explored perceptions of healthcare providers regarding factors that lead to paediatric HIV-infected patients becoming lost to follow-up from care and treatment.

Methods The study was conducted at a large paediatric HIV clinic in Gaborone, Botswana and involved conducting in-depth interviews with clinical staff ($n = 10$). The interviews targeted information about the magnitude of LTFU problems and possible solutions as perceived by the healthcare providers.

Results Respondents perceived factors of LTFU to include issues of HIV-related stigma, caregiver's religious beliefs of being healed, teenage-child rebellion, and concerns about disclosure of their HIV status to others, were characteristic of the patients LTFU. The results also revealed that mental health issues such as depression might not be adequately addressed in HIV clinic settings, perceived as a key underlying factor of LTFU.

Conclusion Our study underscores the psychosocial nature of the issues of LTFU and the need to develop a more holistic approach to treating HIV-infected children.

Disclosure of interest statement Funding for this study was made possible through Fogarty International Centre of the National Institutes of Health, (M. W. Kline – Principal Investigator) under grant number D43 TW01036.

P17.23 IMPLEMENTING PRIORITISED HIV LINKAGE-TO-CARE AND CONTACT TRACING AMONG INDIVIDUALS WITH HIGH HIV VIRAL LOAD IN BALTIMORE, MARYLAND, USA: RESULTS FROM A PILOT PROGRAM

^{1,2}CM Schumacher*, ^{2,3}M Joe, ^{2,3}C Ramsey, ¹A Greiner Safi, ^{2,4,5}P Chaulk, ^{1,6}JM Jennings. ¹Center for Child and Community Health Research, Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA; ²Baltimore City Health Department, Baltimore, Maryland; ³Centers for Disease Control and Prevention, Atlanta, GA, USA; ⁴Division of Infectious Diseases, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA; ⁵Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA; ⁶Department of Epidemiology, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA

10.1136/sextrans-2015-052270.601