

among men and women, including rate of virologic failure, over a 15-year time horizon, starting in 2019. The model simulated the emergence and transmission of resistance mutations to efavirenz-based ART, calibrated to the Kenyan epidemic. Our base-case scenario assumed dolutegravir coverage gradually increased such that, by 2022, 100% of men initiating ART receive dolutegravir and only 40% of women initiating ART receive dolutegravir.

**Results** In 2019, the baseline PDR prevalence among women was 11.5%. In the base-case scenario, PDR prevalence peaked in 2021 to 12.3% and by the end of 2034 was 8.6%. On average over 15 years, among patients with PDR to efavirenz, 61.7% of men and 59.2% of women achieved viral suppression. When we assumed 100% dolutegravir coverage for women by 2022, PDR prevalence among women was 7.8% by the end of 2034.

**Conclusion** Although efavirenz-associated PDR prevalence is projected to decrease over time as dolutegravir coverage expands, the prevalence of PDR will remain high among women, even several years from now. It remains important to identify cost-effective strategies to address PDR in populations for whom dolutegravir is not an option, particularly women.

**Disclosure** No significant relationships.

P199

#### TRENDS IN MOTIVATION AND SETTING FOR HIV TESTING AMONG PEOPLE NEWLY DIAGNOSED WITH HIV IN BRITISH COLUMBIA, CANADA, 2003–2007

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**Background** In British Columbia (BC), Canada, new HIV testing guidelines introduced in 2014 recommended routine offer of HIV testing in an effort to diagnose HIV earlier. We assessed changes in motivation and setting for HIV testing that resulted in a new diagnosis of HIV to evaluate this strategy.

**Methods** In 2013, questions about who initiated testing (provider, client, or other/unknown), test setting (healthcare, community [e.g. outreach, peer], or other), and reason for testing (e.g. recent risk event, routine test, diagnosed with another sexually transmitted or bloodborne infection [STIBBI]) were added to the HIV case report form. Trends from 2003 to 2017 were assessed using Cochran-Armitage tests. HIV testing volumes were determined from the provincial laboratory, which performs >95% of all HIV tests in BC.

**Results** HIV testing increased from 223,300 episodes in 2013 to 337,900 in 2017. New diagnoses of HIV decreased from 265 in 2013 to 186 in 2017 (cumulative total 1,193). An increasing trend was noted for reporting testing in a healthcare setting compared to community or other settings ( $p<0.01$ ), especially among men who have sex with men

( $p<0.01$ ) and people who inject drugs ( $p<0.01$ ). Provider initiated testing was reported by half of all new HIV diagnoses and remained stable ( $p=0.86$ ). There was a decreasing trend for reporting recent risk event/exposure ( $p=0.03$ ) and being notified as a contact ( $p=0.01$ ) as the reason for testing, and an increasing trend for reporting being diagnosed with another STIBBI ( $p=0.03$ ). There was no trend in reporting the reason for testing as routine test ( $p=0.74$ ).

**Conclusion** Routine offer of HIV testing may be increasing the proportion of HIV diagnosed in healthcare settings. The increase in proportion of new HIV diagnoses due to diagnosis of another STIBBI highlights the importance of co-testing of HIV and other STIBBIs.

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P202

#### DEVELOPING A DATABASE WITH SENSITIVE HEALTH INFORMATION: A PROFILE OF PEOPLE LIVING WITH HIV IN NEWFOUNDLAND AND LABRADOR

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**Background** In Newfoundland and Labrador (NL), people living with HIV (PLHIV) primarily receive care through an interdisciplinary HIV specialty clinic, however, HIV care has been transitioning to primary healthcare elsewhere. Developing a comprehensive cohort of PLHIV to help improve healthcare has long been the vision of researchers, clinicians and decision makers. The objective of this study was to develop a de-identified cohort of PLHIV in NL, to be used to inform policy and prioritize healthcare system changes to optimize HIV healthcare in NL and to address gaps in care for PLHIV.

**Methods** Data was collected from a number of different databases and PLHIV were identified as having HIV from three sources: 1. NL Public Health Laboratory data; 2. HIV Clinic data; 3. Medical Administration data.

**Results** The finalized dataset included 317 people who had been diagnosed with HIV in NL as of 1994 and 251 were still alive at the end of data collection. The final database contained a total of 178 variables describing PLHIV health and health care utilization. Only 7% of PLHIV were identified by all three sources suggesting no single provincial HIV data custodian captures all those living with HIV in the province.

**Conclusion** It is important that policy be implemented to merge siloed data sources in order to provide researchers, clinicians and decision makers with the accurate and complete data that is required to conduct sound and precise research, provide appropriate care and allocate resources to health initiatives that can improve the quality of life for PLHIV.

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