demographic, behavioral, social, and clinical characteristics and outcomes.

Results Of the 50 participants, 25 were TW, 6 TM and 19 MSM. ~75% were African American, ~10% white and ~5% Hispanic/Latino; average age 24.18. Results to date shows 27% adherence and 55% persistence. Taking hormones at baseline was inversely related to PrEP persistence, Relative Risk=0.67 (0.39–1.15) $p=0.14$. The trend is similar for adherence, RR=0.65 (0.20–2.1), $p=0.48$.

Conclusion Combining gender affirming hormones and PrEP in community spaces for LGBTQ youth is a novel approach to engage a traditionally hard-to-reach population. While initial data shows low PrEP outcomes, the relatively high number of patients remaining in care (84%) demonstrates an opportunity to improve adherence and clinical outcomes. We observed that integrating hormone therapy with PrEP administration did not positively impact outcomes, suggesting that other factors (e.g. homelessness, trauma) are important. These findings indicate the need to develop interventions designed to address these factors while continuing to integrate PrEP with gender affirming services.

Disclosure No significant relationships.

P264

COMMUNITY PERSPECTIVES ON BACTERIAL STI TESTING FOR GAY, BISEXUAL AND OTHER MEN WHO HAVE SEX WITH MEN IN TORONTO, CANADA

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Background Clinical guidelines recommend that sexually active men who have sex with men (MSM) get tested for bacterial STIs at least once a year, and as often as every 3 months if at ongoing risk. However, few MSM follow this guideline in practice. Our aim was to explore MSM perspectives regarding STI testing services for MSM in Toronto. Results were used to identify and prioritize new STI testing interventions in Toronto.

Methods We conducted 4 focus groups with gay, bisexual and other MSM (gbMSM) in 2017: two with HIV-positive cis-identified gbMSM ($n=16$), one with HIV-negative cis-identified gbMSM ($n=8$), and one with trans-identified gbMSM ($n=3$). Participants were asked about their experience with STI testing in Toronto, barriers and facilitators to testing, and the ideal STI testing process. Focus groups audio recorded, transcribed verbatim, and analyzed using thematic analysis.

Results Major themes centred around deficits in existing clinic contexts and ways to improve them, options for testing services outside of clinics, integration with healthcare, and compassionate care. Participants desired accessible locations/hours; minimal wait times; express/streamlined testing; improved clinic atmosphere/ambience; and minimal crowding/interaction in waiting rooms. Suggested alternatives included online/home

testing; routinizing testing with other services; pharmacies; and clinics at sex-based venues, schools, workplaces, and ASOs. Some participants desired more healthcare continuity in the context of STI testing, and spoke of needs for linkages to primary/HIV care with providers who are welcoming to MSM and transmen. Participants consistently underlined the need to minimize STI-related stigma with compassionate, professional, and non-judgemental care.

Conclusion Participants offered concrete and practical solutions for improving existing services. Their views may also guide efforts to implement new strategies such as online testing. Optimal STI testing would offer variety and choice in the range of testing options available, and would be part of person-centred, LGBT-affirming care.

Disclosure No significant relationships.

P265

CD4 COUNT AS PARAMETER TO ESTIMATE THE TIME OF INFECTION IN HIV POSITIVE MEN HAVING SEX WITH MEN AND ITS SOCIAL IMPLICATIONS

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Background CD4 count is a parameter of clinical significance in the management of HIV infection, especially in staging and treatment. There is no parameter that predicts the time of contracting the infection. This study aims to investigate the average time between testing positive for HIV screening and time of initial infection based on rate of decay in CD4 count among PLHIV MSM and to analyze its social implications.

Methods A total of 2491 MSMs who tested HIV positive were enrolled. The mean CD4 values were determined by age groups. The mean interval between between infection and seropositivity was estimated based on the average annual CD4 decay rate. Data analysis was performed using SPSS.

Results Upon diagnosis, the mean CD4 values were 372 cells/ μ l for those aged 20 and below, which was found to be significantly higher than 323 cells/ μ l for 21–30 group ($p=0.007$), 284 cells/ μ l for 31–40 group ($p=0.0000$), 279 cells/ μ l for 41–50 group ($p=0.015$). Thus, the significant difference among age groups and WHO CD4 staging ($p<0.000$). The average time between infection and testing is 5.81 years among ages 20 and below and 6.49 among 20–30 age group, estimating an average infection age of 13.2 and 19.5, respectively, implicating that 73.5% of the sample likely had been infected 20 years and below.

Conclusion Being diagnosed with a CD4 count of 200–499 cells/ μ l is common among all age groups. It is consistent with the count estimated from the average time of infection among all age groups. Three quarters of the patients were likely to have been infected below 20 years old. It is consistent with the 8.1 person-years incidence density among 21 years and below in the 2012–2016 data from the same facility. This emphasizes the need to empower the youth's and healthcare providers' positivity towards sexual health through legislation, education, and awareness.

Disclosure No significant relationships.