

previous warts, HIV status to IMIQ 5% (16W), or PDX 0.15% cream (4W, extended to 16W if warts persist). Simultaneous blinded randomisation to Gardasil® or saline control (0–2–6 months). Composite primary outcome of wart clearance at 16W and remaining clear to 48W; analysis by logistic regression with multiple imputation for missing follow-up values. Economic evaluation considered the costs per quality-adjusted life year (QALY) for the National Health Service in England.

**Results** 503 participants enrolled; mean age 31 years; 66% male (20% of males MSM); 50% previous warts; 2% known HIV+. Adjusted OR (95%CI) for IMIQ relative to PDX 0.81 (0.54, 1.23); vaccine relative to placebo 1.46 (0.97, 2.20). aOR for primary outcome components (same comparators) of wart-free at W16 0.77 (0.52,1.14) and 1.30 (0.89,1.91) and remaining wart-free at 48W (in those wart-free at W16) 0.98 (0.54,1.78) and 1.39 (0.73,2.63) respectively. PDX without qHPV vaccine had the highest probability of being cost-effective across willingness-to-pay thresholds of GBP0–50,000/QALY. Adding qHPV vaccine to PDX exceeded GBP80,000/QALY.

**Conclusion** Though the effect of vaccine was not statistically significant, the odds of clearance at 16W+48W (primary outcome) were 46% higher with vaccine, consistent with the effects seen in component outcomes, wart-free at 16W, and 48W. IMIQ and PDX had similar efficacy; there was no evidence of a lower recurrence with IMIQ. PDX without qHPV vaccine is likely most cost-effective at the current qHPV price, but addition of qHPV may become cost-effective with reduced pricing.

**Disclosure** No significant relationships.

#### 006.5 DO TREATMENT RATES SUFFER IN A LOW-TOUCH SCREENING MODEL? NEW YORK CITY SEXUAL HEALTH CLINICS, 2017–2018

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**Background** Low-touch (i.e. limited staff interaction) models for asymptomatic STI screening have been widely adopted in sexual health clinics (SHCs) and can improve clinic flow and patients' experience. In New York City SHCs, asymptomatic patients who do not report contact to STI screen for urogenital and extragenital bacterial STI using self-collected specimens without a medical encounter. We evaluated treatment rates for *Neisseria gonorrhoea* (GC) cases detected by this low-touch, self-screening model.

**Methods** We identified men-who-have-sex-with-men (MSM) who tested GC-positive by urogenital or extragenital nucleic acid amplification testing at any visit type (self-screening or standard clinician) during 01/2017–06/2018. Among GC cases that had not been presumptively treated, we assessed the number and percent of asymptomatic cases that returned for

treatment within 30 days, and HIV pre-exposure prophylaxis (PrEP) use. We used Kaplan-Meier methods to examine time-to-treatment by visit type.

**Results** Of 3,944 GC cases, 2,268 were presumptively treated and 1,676 needed to return for treatment. Among returning patients, median time-to-treatment was 6 days (IQR: 4–8). Cases detected at self-screening visits had shorter time-to-treatment than those detected at standard visits ( $p=0.008$ ). Among GC cases detected at self-screening visits, 85% (454/534) were treated  $\leq 14$  days, and 90% (480/534)  $\leq 30$  days, compared to 80% (917/1,142) of standard cases treated  $\leq 14$  days, and 87% (991/1,142)  $\leq 30$  days after the visit. HIV-negative men with rectal GC had shorter time-to-treatment following self-screening versus standard visits ( $p=0.007$ ), and fewer remained untreated by 30 days (self-screening: 7% versus standard: 13%;  $p=0.02$ ). Of 76 HIV-negative men with rectal GC who were lost to follow-up, 22 (29%) were documented to be taking HIV PrEP at time of testing/screening.

**Conclusion** Among HIV-negative MSM with rectal GC, a group for whom delayed treatment may increase risk for HIV acquisition, a low-touch/self-screening model results in overall treatment rates and times-to-treatment that compare favorably to a standard clinician model.

**Disclosure** No significant relationships.

#### 006.6 REDUCTION IN ADHERENCE TO ANTIRETROVIRAL THERAPY DURING POSTPARTUM: FINDINGS FROM A PROSPECTIVE COHORT STUDY

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**Background** The WHO recommended breastfeeding as the best feeding option for women with HIV in sub-Saharan Africa. Adherence to antiretroviral therapy is important for breastfeeding mothers to prevent vertical transmission of HIV. There is evidence that pregnancy tends to drive adherence of antiretroviral therapy among women living with HIV, however it is unclear whether they maintain the level of adherence at pregnancy during the postpartum period. This study assesses the rate of drop-off in adherence in the post-partum period from the prospective cohort study of mother-infant pairs in Eastern Cape, South Africa.

**Methods** We conducted a follow up study on 485 mothers with HIV at 18 months post delivery to elucidate on their adherence to ART during their postpartum period. We obtained relevant items on demographic, lifestyle and self-reported adherence to ART. Adherence was measured using 7-items questions to probe adherence to ART since birth of their child to the previous night of the survey. Logistic regression (model) analysis was fitted to determine the predictors of good adherence in the cohort.

**Results** The mean age of the participants was 32.91 years (Standard Deviation 5.74). About 64% of the women reported complete adherence to ART representing a 5% percentage drop-off in adherence compared to the rate recorded during pregnancy. In the adjusted model, alcohol use in the last 12