(95% CI 4.7, 10.2). The majority of incident STIs were new infections: 79 of 119 CT infections, 41 of 48 GC infections, and 23 of 29 TV infections diagnosed were in women who did not have these infections at enrollment. The majority of these infections were asymptomatic.

Conclusion The prevalence and incidence of treatable STIs were high among young African women initiating PrEP. Diagnostic STI testing is important and innovative strategies that reduce STI acquisition, complications, and their potential impact on future fertility, need evaluation within the context of PrEP services where currently syndromic STI management is the standard of care.

Disclosure No significant relationships.

010.4 SCALING UP HCV SCREENING AND TREATMENT FOR ELIMINATING HCV AMONG MSM IN UK IN THE ERA OF HIV PRE-EXPOSURE PROPHYLAXIS

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Background Routine HIV pre-exposure prophylaxis (PrEP) and HIV care appointments provide opportunities for screening men who have sex with men (MSM) for hepatitis C virus infection (HCV). However, levels of screening required for achieving the WHO elimination target of reducing HCV incidence by 90% by 2030 among all MSM are unknown.

Methods An HCV/HIV transmission model was calibrated to UK prevalence of HIV (5.9%) and chronic HCV infection among HIV-positive MSM (10.0%). Assuming 12.5% coverage of PrEP among HIV-negative MSM, we evaluated the impact on HCV incidence (2018–2030) of HCV screening every 12/6/3-months (and completing treatment within 6 months of diagnosis) in PrEP users and/or HIV-diagnosed MSM. We then estimated the additional screening required among HIV-negative non-PrEP users to achieve a 90% reduction in overall incidence by 2025/2030. The effect of a 50% reduction in condom use among PrEP users (risk compensation) was estimated.

Results Without risk compensation, PrEP scale-up decreases HCV incidence by 9.5% by 2030, whereas it increases by 26.5% with risk compensation. Screening and treating PrEP users for HCV every 12/6/3-months decreases HCV incidence by 41/46/48%, respectively, increasing to 74/81/83% if HIV-diagnosed MSM are also screened at the same frequencies. Risk compensation reduces these latter projections by <5%. To achieve a 90% reduction in HCV incidence by 2030 (values in bracket are with risk compensation), HIV-negative MSM not on PrEP require screening every 5.2 (4.5) years if MSM on PrEP and HIV-diagnosed MSM are screened every 6-months, decreasing to every 2.6 (2.3) years for the 2025 target. For 25% PrEP coverage, then the 2030 HCV

elimination target may be reached without screening HIV-negative MSM not on PrEP.

Conclusion Increased screening of all MSM (particularly HIV-diagnosed MSM and MSM on PrEP) is required to achieve the WHO HCV-elimination targets for MSM in the UK.

Disclosure No significant relationships.

010.5 PATTERNS OF HIV PRE-EXPOSURE PROPHYLAXIS CARE ONE YEAR AFTER INITIATING PREP, BALTIMORE CITY, MARYLAND 2015–2018

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10.1136/sextrans-2019-sti.162

Background Persistent HIV pre-exposure prophylaxis (PrEP) use is critical to preventing HIV acquisition. U.S. Centers for Disease Control and Prevention (CDC) recommends quarterly clinical evaluation for individuals using PrEP. Individual-level adherence to quarterly PrEP-care visits is largely unknown. Our objective was to describe patterns of quarterly PrEP-care visit attendance among individuals enrolled in a large demonstration project to increase PrEP delivery in Baltimore City, Maryland.

Methods The project was a collaboration between a city health department, an academic evaluation partner, 6 clinical sites and one community based organization (CBO). Demographic and quarterly PrEP-care visit information from individuals initiating PrEP between October 1, 2015 and August 31, 2017 was abstracted from medical records using standardized forms. Participants were followed for one year. PrEP-care was categorized as ‘Persistent’ (attending all quarterly PrEP-care visits), ‘Episodic’ (missing ≥ 1 PrEP-care visit and re-engaging PrEP-care visit), or ‘Discontinued’ (lost to follow-up after missing ≥ 1 PrEP-care visit).

Results During the study period, 333 individuals initiated PrEP, among whom 52.9% (176) were Black/African-American, 82.3% (274) cisgender male, 73.6% (245) men who have sex with men (MSM), and 47.7% (159) aged 25–24 years. 9.0% (30), 40.5% (135), and 50.5% (168) were persistent, episodic and discontinued PrEP-care users, respectively. Over half (51.1%, 69/135) of episodic users missed the first quarterly visit; mean time to PrEP re-engaging was 6.3 months (SD: 2.18). About half (45.2%, 76/168) of those discontinuing PrEP-care did so within 3-months.

Conclusion Over one year, < 10% of individuals initiating PrEP were persistently in PrEP-care, and half discontinued PrEP-care completely. This suggests PrEP’s effectiveness in

reducing HIV transmission in Baltimore City may be limited. Future work should focus on identifying individual and structural barriers and facilitators to discontinuing PrEP-care and factors associated with re-engaging PrEP-care to inform interventions to improve persistent PrEP-care, and decrease ongoing HIV transmission.

Disclosure No significant relationships.

010.6 A LONGITUDINAL ANALYSIS OF MEN WHO HAVE SEX WITH MEN'S CONDOM USE AND ATTITUDES DURING HIV ANTIRETROVIRAL PREVENTION SCALE-UP

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Background Within British Columbia, men who have sex with men (MSM) comprise an increasing proportion of new HIV diagnoses (60% in 2016). We sought to identify temporal trends in condom-use and condom-related attitudes among MSM, especially in relation to antiretroviral-based prevention scale-up.

Methods A prospective biobehavioural cohort of sexually-active MSM in Metro Vancouver were recruited using respondent-driven sampling (RDS). Every six months, participants self-completed questionnaires. We analyzed temporal trends (6-month periods) in condomless sex (binary outcome) and condom-related attitudes (continuous outcomes) using 3-level generalized linear mixed model (visit; participant; RDS chain). Statistical interactions were tested between time and antiretroviral treatment/pre-exposure prophylaxis (PrEP) use.

Results Between 03/2015–02/2018, 520 participants (32.1% HIV-positive) completed 1861 study visits. Over time, reporting any condomless anal sex with an unknown/opposite status partner increased for HIV-negative men (OR=1.20, 95% CI:1.03–1.40) and decreased for HIV-positive men (OR=0.83, 95%CI:0.73–0.94). Correct Condom Use Self-Efficacy scale scores decreased among HIV-positive men (B=-0.296, p<0.001) but remained unchanged among HIV-negative men (p=0.167). Overall, Condom Barriers Experience subscale scores decreased, indicating more problems over time (B=-0.236, p<0.001). Other individual items indicated that fewer men reported they 'can always get condoms' (B=-0.023, p=0.003), 'always have condoms when I have sex' (B=-0.028, p=0.006), and 'can always ask sexual partners to use condoms' (B=-0.027, p=0.002). Over time, the ability to 'say no' to condomless sex increased among HIV-negative men using PrEP (B=0.172, p=0.023), but decreased among HIV-negative men not using PrEP (B=-0.049, p=0.001) (interaction, p=0.004).

Conclusion MSM reported changing condom experiences over time, including decreased condom access, availability, and norms. HIV-positive men had less condomless sex with sero-discordant partners and reported more difficulties using condoms over time. PrEP-using men reported greater agency to decline condomless sex; the opposite was true for other HIV-

negative men. Innovations in individual and community-level condom promotion and interventions are needed, especially for HIV-negative men not using PrEP.

Disclosure No significant relationships.

O11 – IMPROVING THE EQUITY AND EFFECTIVENESS OF SEXUAL HEALTH CARE

Tuesday, July 16, 2019 4:15 PM – 5:45 PM

011.1 AN UPDATE ON THE PERFORMANCE OF STI SERVICES FOR GAY AND BISEXUAL MEN ACROSS 40 CITIES: PRELIMINARY RESULTS FROM EMIS-2017

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Background Rectal manifestations of sexually transmitted infections (STIs) compromise the health of gay and bisexual men. In 2010 across 40 cities among men-who-have-sex-with-men (MSM) screened for STIs, anal swabbing was highest in London and Amsterdam with rates of more than 72%, but low across most other European cities. We repeated the comparison of diagnostic procedures for MSM across the same European cities, in order to see if in 2017 the gap between London/Amsterdam and other European cities has narrowed.

Methods We used data from the European MSM Internet Survey (EMIS-2017), a sexual health survey that was accessible online in 33 languages from 10/2017 to 01/2018. As sexual healthcare for MSM in most countries is organised locally, we chose cities for comparison and focus on a subsample of 38,439 men living the same 40 European cities. We applied multivariable regression models to compare the odds of having received anal swabbing in the 12 months, controlling for age, HIV diagnosis, and the number of sexual partners.

Results In 2017, the proportion of respondents tested for STIs in the previous 12 months in the absence of symptoms ranged from 19% in Belgrade to 59% in London. At individual level, compared to London, the Adjusted Odds Ratio (AOR) for having received anal swabbing ranged from 0.02 in Belgrade, Bucharest, and Istanbul (p<0.001) to 0.80 in Oslo (p<0.05), while no statistical significant difference was seen for Amsterdam and Dublin. Many Western European cities (Barcelona, Berlin, Brussels, Hamburg, Lisbon, Munich, Paris, Porto, Prague, Valencia, Zurich) have substantially narrowed their performance distance to London, but many Eastern European cities (Kiev, Riga, Sofia, St.Petersburg, Tallinn) have moved even further away since 2010.

Conclusion Although comprehensive STI-screening in gay and other MSM has increased across many European cities, rectal STIs continue to be under-diagnosed, particularly in Eastern Europe.

Disclosure No significant relationships.