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Session: 148. HIV: General Epidemiology

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Background. In Peru, where the HIV epidemic is concentrated among men who have sex with men (MSM), incidence has not changed appreciably over the last decade despite the rapid scale-up of free antiretroviral treatment (ART). New strategies for delivering effective HIV testing and prevention services to at-risk populations are greatly needed. Because most people in Peru live at home with family, it may be difficult to bring new sex partners, sex-on-premise venues (SOPVs)—such as saunas, sex clubs, and hourly hotels—to represent opportune sites at which to offer targeted HIV testing and prevention interventions.

From November 26, 2018 through April 15, 2019, we conducted a cross-sectional web-based survey using REDCap to assess the prevalence of SOPV attendance and associated sexual risk behaviors among MSM in Lima, Peru. SOPVs were defined as saunas, sex clubs, adult movie theaters, hotels, or bars/disco known to permit sex. We recruited participants by disseminating an anonymous survey link through local gay social media networks, with no monetary incentive to complete the survey. We asked participants how/where they met any sex partners from the prior 3 months, where they went for sex, and about HIV-associated sexual risk factors, including self-reported HIV status. We used the Pearson chi-squared test and Student’s t-test to assess whether the frequency of sexual risk behaviors differed based on SOPV attendance.

Results. Among n = 324 cis-gender MSM completing the survey, 16% identified as bisexual. Median age was 36 years, 62% lived at home with family, 50% had a university education or higher, and 29% reported being HIV+. 65% of respondents reported attending an SOPV to meet a partner and/or have sex in the prior 3 months. SOPV attendees were significantly more likely to report transactional sex, group sex, sex under the influence of alcohol, popper use, and have a higher number of sex partners (Table). Conclusion. SOPV attendance is common among MSM in Lima and associated with higher levels of sexual behavioral risk factors. In light of this, SOPV’s warrant further consideration as potential sites of outreach to offer HIV testing and prevention interventions designed to reach MSM at high risk for HIV infection.

Disclosures. All authors: No reported disclosures.

1255. Comparison in AIDS-Related Mortality Between African Americans and Whites with Human Immunodeficiency Virus During the HAART Era

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Background. Higher death rates have been reported in African American (AA) compared with non-Hispanic whites with HIV infection. However, there are no published studies of attributable mortality by racial and ethnic groups. We evaluated differences in attributable mortality between AA and whites.

Methods. We conducted a retrospective review of all persons with HIV infection who received care at the University of Cincinnati Medical Center whose deaths were between 1996 and 2017. We abstracted chart data using a standard data tool and identified all deaths reported to the social security national database. Probable cause of death was assigned using the EuroSidA CoDe methodology. Primary endpoint was to compare AIDS vs. non-AIDS-related deaths between AA and whites.

Results. Initial analysis of 588 deaths were reported through 2007 (44% AA and 55% white). The median age at the time of HIV diagnosis was 37 years for AA patients and 36 years for white patients, while median age at the time of death was 43 years for AA and 42 years for whites (P = ns). 16.9% of AA were women, 2.6% were transsexual; 10.3% of whites were women and 1% were transsexual (P < 0.02). Risk factors for HIV acquisition included: MSM, 61.3% of whites vs. 46.0% AA; heterosexual contact, 11.7% of whites vs. 13.4% AA; and injection drug use 16.9% white vs. 18.3% AA (P < 0.0001). African Americans had both lower median CD4 counts at the time of diagnosis and within 3–6 months prior to death (167 and 68 cells/mm3, respectively) and were significantly more likely to be infected with (214 and 103 cells/mm3, respectively) for both). There was no statistical significance of having AIDS at entry into the practice between AA and whites (P = 0.79). AIDS-related deaths accounted for a larger percentage of overall deaths within white patients (51%) compared with AA patients (40%) (P = 0.03).

Conclusion. Our data show that while a greater percent of AIDS-related deaths were found in whites vs. AA in the early HAART era, AA patients typically have lower CD4 counts at the time of diagnosis and within 3–6 months prior to death. Future analyses will examine more specific attributable mortality due to HIV viremia and changes in causes of death over later HAART era. Understanding factors associated with mortality may inform care models to prevent or delay future deaths.

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1256. Contemporary Evaluation of Racial/Ethnic Disparities in Survival and Disease Progression Among People with HIV in the US Midwest

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Background. Combating HIV-related disparities is a major goal of the 2020 National HIV/AIDS Strategy. However, research on HIV disparities has primarily been conducted in urban settings. A 1997–2007 study of people with HIV (PWH) at our clinic noted significantly increased mortality among high-risk non-Hispanic (NH) Black PWH (73%) compared with NH Whites (88%). This study evaluated demographic disparities in survival and disease progression in a large Midwest clinical cohort.

Methods. We retrospectively reviewed records of 1,396 PWH receiving treatment at an HIV Clinic in Ohio, Nebraska from 2012 through 2017. We included patients over 19 years old with diagnosed HIV, a minimum of two visits, and no lapse in care ≥2 years. Patients were stratified into low-risk (CD4 > 100 cells/mm3 and HIV viral load < 250,000 copies/mL) and high-risk (all others) groups. Cox proportional hazard models and Kaplan–Meier curves with log–rank tests compared patient demographic and mortality. Generalized estimating equations modeled change in CD4 count over time.

Results. No significant difference in mortality was noted across race/ethnicity categories (P = 0.286). Several clinical and demographic characteristics, including CD4 counts < 500 cells/mm3, were significantly associated with increased mortality (Figure 1). Compared with NH Whites, NH Black CD4 counts (Figure 2) were significantly lower for NH Blacks (P = 0.001), Hispanics (P = 0.006), and Others (P = 0.013). High-risk status was associated with mortality (P < 0.001), but no significant differences in mortality were noted across race/ethnicity categories after stratifying for patient risk status (Figures 3 and 4).

Conclusion. Significant racial/ethnic disparities in HIV disease progression among PWH at a Midwest HIV Clinic persist. However, in contrast to the 1997–2007 study, disparities in survival were not observed among high-risk PWH. As our patients demographics are essentially the same, the reelaboration effect suggests needed investigation of whether these changes are the result of better antiretroviral efficacy or if social determinants of health in the region have improved. Systems-level interventions are needed to ensure all PWH benefit from continuing advances in HIV research and care.