

### 021 HIV TESTING IN ABORTION SERVICES: MISSED OPPORTUNITIES FOR EARLIER DIAGNOSIS

Louise Logan\*, Kate Folkard, Nicky Connor, Fortune Ncube, Anthony Nardone. *Public Health England, London, UK*

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**Introduction** The 2016 National Institute of Clinical Excellence (NICE) HIV testing guidelines reiterated the need to include HIV testing in abortion services. This survey aimed to determine whether HIV testing was commissioned in abortion services and how much testing was performed.

**Methods** 143 CCGs were invited to provide service specifications and monitoring data for the number of women seen for care, tested for HIV and diagnosed as HIV positive.

**Results** Of 103 CCGs that responded, 45 (42%) stipulated that HIV testing should be offered to all women, 10 (9%) requested that providers work towards this, 27 (26%) requested sign-posting and 21 (20%) had no mention of HIV. All 10 CCGs in extremely high HIV prevalence areas (where diagnosed HIV is >5/1000) commissioned HIV testing. 54% (14/26) of CCGs in high prevalence areas (diagnosed HIV is 2–5/1000) and 45% (30/367) of CCGs in low prevalence areas (diagnosed HIV is <2/1000) did so. 40 of 103 CCGs reported testing data. Of 35,023 women reported as seen for care, 35% (12,179) were tested for HIV and 0.14% (17) tested positive. Uptake ranged from 0% to 97% and positivity ranged from 0% to 0.53%.

**Discussion** Overall positivity rates exceed those required to make HIV testing cost effective. Less than half the CCGs reported commissioning HIV testing in abortion services, including 54% in high prevalence areas. These gaps in service provision mean opportunities to diagnose women earlier; thereby improving their prognosis and reducing undiagnosed infection were missed. Further advocacy for testing HIV testing in abortion services is required.

### 022 ACCEPTABILITY OF HIV SELF-TESTING AMONG MEN WHO HAVE SEX WITH MEN ATTENDING A SEX ON PREMISES VENUE IN BRIGHTON: A CROSS SECTIONAL SURVEY

<sup>1</sup>Aliza Amlani, <sup>1</sup>Gillian Dean, <sup>1</sup>Suneeta Soni, <sup>2</sup>Carlos Peralta, <sup>3</sup>Carrie Llewelyn, <sup>1,4</sup>Jaime Vera\*. <sup>1</sup>HIV Department, Brighton and Sussex University Hospital NHS trust, Brighton, UK; <sup>2</sup>School of Art, Design and Media, University of Brighton, Brighton, UK; <sup>3</sup>Department of Public Health and Primary Care, Brighton and Sussex Medical School, Brighton, UK; <sup>4</sup>Department of Infection and Global Health, Brighton and Sussex Medical School, Brighton, UK

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**Introduction** Interventions to target and test men who have sex with men (MSM) for HIV are crucial to reduce incidence. Accessing traditional healthcare services can act as a barrier to HIV testing. Testing in outreach settings, such as sex on premises venues (SOPV), may be more successful. This study aimed to determine the acceptability of HIV self-testing in MSM sauna clients.

**Methods** An anonymous cross sectional, electronic/paper survey was conducted in a male SOPV in Brighton. Results were collated using Survey Monkey.

**Results** A total of 281 clients responded. 23% were aged 25–34 years, 16% 35–44 years and 37% 45–64 years. 32% reported never testing for HIV; 56% had not tested in the last 12 months; 44% felt they were not at risk of HIV. 93% would consider collecting a HIV self-test at the sauna with 40% wanting to test there and then, and 53% preferring to test at home.

**Discussion** A significant number of MSM attending this SOPV felt they were not at risk of HIV, and had never tested for HIV or not tested for over 1 year. Despite this, most individuals found testing at the SOPV acceptable, and would consider HIV self-testing if it were available. Innovative methods to enable HIV self-testing in venues frequented by high risk MSM are urgently needed.

### 023 IMPACT OF SERVICE RELOCATION ON NEISSERIA GONORRHOEAE CULTURE SENSITIVITIES

<sup>1</sup>Harriet Wallace\*, <sup>1</sup>Marshall T Coates, <sup>2</sup>Helen Inns, <sup>1</sup>Janet Wilson, <sup>1,2</sup>Emma Page. <sup>1</sup>Leeds Sexual Health, Leeds Teaching Hospitals Trust, Leeds, UK; <sup>2</sup>Department of microbiology, Leeds Teaching Hospitals Trust, Leeds, UK

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**Introduction** Our hospital-based GUM clinic *Neisseria gonorrhoeae* (NG) cultures were directly plated, stored in a CO<sub>2</sub>-enriched incubator and portered twice daily to onsite microbiology. Service relocation in November 2015 to a citycentre hub and 4 community sites forced change due to distance from microbiology. Community samples are taken on charcoal swabs, taxied to the hub at close of clinic for plating. Hub samples are directly plated. All plates are incubated 48–72hrs and transported daily in CO<sub>2</sub>-enriched environment (not temperature controlled).

**Aims/objectives** Evaluate sensitivity for NG culture against positive NAAT before and after service relocation.

**Methods** Cases of NAAT positive NG with a culture taken January–June 2015 were compared with cases January–June 2016. Hub and community results were merged in 2016 due to small numbers from community.

**Results** Overall sensitivity per infected patient (any positive NAAT and culture from any site) 2016 176/253 (70%) versus 2015 218/279 (78%), OR 0.64 (95% CI 0.43–0.94), p=0.02. Total sites with positive NAAT and associated culture processed: 2015 n=375, 2016 n=333.

Culture sensitivity by site of positive NAAT 2016 versus 2015: Urogenital 78% versus 85% (OR 0.63(0.37–1.08); p=0.09), Rectal 39% versus 55% (OR 0.52(0.29–0.94); p=0.03), Pharynx 33% versus 51% (OR 0.49(0.25–0.96); p=0.04).

**Discussion** Despite extensive review of evidence to identify systems that would maintain NG culture sensitivity, the overall sensitivity of NG culture has dropped significantly since the community move. There has been a non-significant decline in urogenital culture sensitivity but significant reductions in rectal and pharyngeal sensitivities. A new method for NG transportation is now under consideration.